

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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6260

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6260

CERTIFICATE OF DEATH

06244

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. d. STREET ADDRESS HARTFORD ROAD 3505 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jean Middle Amrein Last Amrein		4. DATE OF DEATH Month June Day 8 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1882
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Muir		14. MOTHER'S MAIDEN NAME Elizabeth Robertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Raymond E. Amrein		Englewood Colorado	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1961 to June 8, 1961 , that (I) (we) last saw the deceased alive on June 7, 1961 , and that death occurred at 8 AM , from the causes and on the date stated above.			
22a. SIGNATURE DR Miles JMD		22b. DATE SIGNED 6.8.61	
22c. PHYSICIAN'S NAME (Type) LR MILES, JR., M.D.		22d. ADDRESS LONA CONING, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/61	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25a. REC'D BY REGISTRAR DATE JUN 12 '61	
ADDRESS Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE William S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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6261
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06245

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Memorial Hospital			d. STREET ADDRESS 219 Arch Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle T. Last Barney			4. DATE OF DEATH Month June Day 15 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1887		9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lumber Insp.		10b. KIND OF BUSINESS OR INDUSTRY Planing Mill		11. BIRTHPLACE (State or foreign country) Buck Valley, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Barney			14. MOTHER'S MAIDEN NAME Ruth Shives		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Jessie E. Barney, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASHD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular accident, hemorrhage - BP 14					INTERVAL BETWEEN ONSET AND DEATH 15 min 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Feb 1 1957 , 19 61 , to 6/15 , 19 61 , that (I) (we) last saw the deceased alive on 6-7-1961 , and that death occurred at 4:59 PM , from the causes and on the date stated above.					
22a. SIGNATURE William P. Imes		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/17/61	
22c. PHYSICIAN'S NAME (Type) Dr. William P. Imes, M.D.		22d. ADDRESS 441 N. Centre St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-18-1961		23c. NAME OF CEMETERY OR CREMATORY Christian Cem.	
23d. LOCATION (City, town, or county) Buck Valley, Pa.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 22 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraw					

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UNITED STATES OF AMERICA

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Comptroller

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6262

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06246

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1 Yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAURA Middle ETTA Last BEARD				4. DATE OF DEATH Month June Day 3 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1874	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stephen Knootz				14. MOTHER'S MAIDEN NAME Rachel Durst			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Harry Kyle Barton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, left 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) Also old myocardial fibrosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Months Years 11							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 3, 1961			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 6/5/61		22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Boul				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR JUN 6 '61	
				24b. REGISTRAR'S SIGNATURE Charles S. Hume			

MEDICAL CERTIFICATION

(M)

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6652

6652

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 1, 1961		Home	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Medical History		Previous Illnesses		Family History		Social History		Other	
Hypertension		None		None		None		None	
Treatment		Autopsy		Burial		Disposition of Body		Remarks	
Medicine		No		Yes		Buried		None	
Signature of Examiner		Signature of Coroner		Signature of Registrar		Signature of Physician		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Date of Death		Date of Burial		Date of Disposition		Date of Remarks	
Jan 3, 1961		Jan 1, 1961		Jan 1, 1961		Jan 1, 1961		Jan 1, 1961	

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6263 Items 8 & 9 Film G290 7/3/61 iwr											
CERTIFICATE OF DEATH											
06247											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN lb. 15 days 9 hrs 29 mins. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL					d. STREET ADDRESS 412 PULASKI STREET						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First FRED Middle M.athias Last BECK					4. DATE OF DEATH Month 6 Day 24 Year 19 61						
5. SEX MALE					6. COLOR OR RACE WHITE						
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 1/30/1880						
9. AGE (In years last birthday) 81 yrs.					IF UNDER 1 YEAR Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUMBERLAND OFFICE SUPPLY					10b. KIND OF BUSINESS OR INDUSTRY SELLING						
11. BIRTHPLACE (County & State, or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? UNITED STATES						
13. FATHER'S NAME JOHN D. (DECEASED)					14. MOTHER'S MAIDEN NAME FRANCES (DECEASED) Fradiska						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. CHART						
17. INFORMANT Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Myocardial Degeneration (c) Arteriosclerotic Cardio-Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-9 , 19 61 , to 6-24 , 19 61 , that (I) (we) last saw the deceased alive on 6-24 , 19 61 , and that death occurred at 9:49 AM, from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Leo H. Ley, Jr. M.D.										22b. DATE SIGNED 6/27/61	
22c. PHYSICIAN'S NAME (Type) LEO H. LEY, JR. M.D.										22d. ADDRESS 456 N. CENTRE STREET; CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 6/17/61	
23c. NAME OF CEMETERY OR CREMATORY St. Luke's Lutheran Cem.										23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cymberland, Maryland										25a. REC'D BY REGISTRAR JUN 29 '61	
										25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06248

6264

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 1 HR. 35 MIN. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 209 WEST SECOND STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY VIRGINIA BECK				4. DATE OF DEATH JUNE 15, 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1917 JULY 18, 1917 43 yrs.	
9. AGE (In years last birthday) 43 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Ownhome		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME HARRY NEFF		14. MOTHER'S MAIDEN NAME MAE LOWERY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 1 DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/15/61 7:20 P.M. to 6/15/61 , that (I) (we) last saw the deceased alive on 6/15/61 , and that death occurred at 6/15/61 M, from the causes and on the date stated above.		22a. SIGNATURE DR. R. J. WILLIAMS		22b. DATE SIGNED 6/15/61		22c. PHYSICIAN'S NAME (Type)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUN 22 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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ALLIANCE

MARYLAND

CUMBERLAND

1 PM, 32 MIN.

CUMBERLAND

GENERAL & HOSPITAL
GENERAL HOSPITAL

500 WEST SECOND STREET

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JUNE 17,

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JULY 15, 1917 40 1/2

WHITE

U. S. A.

CUMBERLAND, MD.

Home wife of home

MRS. LOREY

HARRY KEFE

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GENERAL HOSPITAL - CUMBERLAND, MARYLAND

No.

122 C. CENTER ST., CUMBERLAND MARYLAND

DR. R. M. WILLIAMS

6-18-41 HALLIAMS (JULIA) R. TH. CUMBERLAND, MD.

JUN 23 1941

Dr. R. M. Williams, Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

6265

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06249

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loartown		c. LENGTH OF STAY IN 1b 6 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loartown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) NORA First Middle Last A. BENNETT		4. DATE OF DEATH Month June Day 6 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1875
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Bedford Co., Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Steckman		14. MOTHER'S MAIDEN NAME Laura Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Hazel Gilkey, Loartown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/6 19 60 to 6/6 19 61 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 6/5 19 61 , and that death occurred at 4:45 PM from the causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE 6/8/61	
22c. PHYSICIAN'S NAME (Type) George Simons, M.D.		22d. ADDRESS Algonquin Hotel, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/9/61	
23c. NAME OF CEMETERY OR CREMATORY Memorial Burial Park		23d. LOCATION (City, town, or county) (State) Bedford, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE JUN 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

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CERTIFICATE OF DEATH

1918

County of ... State of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6266

06250

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 723 WASHINGTON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUTIE D. BENSON		4. DATE OF DEATH JUNE 23, 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1878
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) EXXERSLEY MD. Frostburg		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MILES T. DELANO		14. OTHER'S MAIDEN NAME JOSEPHINE KELER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure and Coronary Arteriosclerosis and Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Men. arteriosclerosis DUE TO (c) Men. arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) macrocytic anemia, controlled by treatment 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While Not While at work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8 am to 8:55 p.m. on 23 June, 1961 , that (I) (we) last saw the deceased alive on 23 June, 1961 and that death occurred at 8:55 p.m. from the causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer M.D.		22b. DATE SIGNED 24 June 61	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/25/61	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City, town or county) (State) Frostburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR JUN 29 1961 DATE JUN 29 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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ALLEGANY

HARYLAND

ALLEGANY

CUMBERLAND

3 DAYS

CUMBERLAND

MEMORIAL & WASHINGTON AVES.
MEMORIAL HOSPITAL

123 WASHINGTON ST.

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JUNE

BENSON

D.

LUTIE

FEMALE WHITE

1-1878

1878

11 ELLERSIE, NO. PROSPERITY, S. A.

JOSEPHINE WELER

MILES T. BELAND

MEMORIAL HOSPITAL - CUMBERLAND, MD.

1000

1000

123 S. CENTRE ST., CUMBERLAND, MD.

DR. W. A. VAN COTER

123 S. CENTRE ST., CUMBERLAND, MD.

John S. Hester, Cumberland, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expounded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

<div>1</div> <div>6267</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>06251</div>											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY WEST VIRGINIA					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG				d. STREET ADDRESS 85X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First OLIE Middle C. Last BLACK						4. DATE OF DEATH Month JUNE Day 24 Year 19 61					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 18, 1895		9. AGE (in years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EDWIN BLACK						14. MOTHER'S MAIDEN NAME MINNIE REED					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest and congestive failure 411 X DUE TO Chronic valvular heart disease with aortic stenosis Conditions, if any, which gave rise to immediate cause (b) Chronic valvular heart disease with aortic stenosis (c) arteriosclerotic cardiovascular disease cause last. Chronic Bronchitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 23 June 1961 to 24 June 1961 ; that (I) (we) last saw the deceased alive on 24 June 1961 , and that death occurred at 2:28 A.M. from the causes and on the date stated above.											
22a. SIGNATURE W. Alfred Van Ormer M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 24 June 61			
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER						22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 26, 1961		23c. NAME OF CEMETERY OR CREMATORY BLACK FAMILY CEMETERY		23d. LOCATION (City, town or county) MOUTH OF SENECA, W. VA.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE J. Blaine Schaffer						ADDRESS Petersburg W. Va.		25a. REC'D BY REGISTRAR JUN 29 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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WEST VIRGINIA

ALLEGANY

PETERSBURG

CUMBERLAND

MEMORIAL HOSPITAL

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FEB. 17, 1967

WHITE

WEST VIRGINIA

FAIRFAX

WHITE REED

EDWIN BLACK

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MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

2:30 P.M.

155 S. CALICO STREET, CUMBERLAND, D.

DR. K. A. VAN COTT

BLACK FAMILY GENEALOGY

JUNE 28, 1961

HOSPITAL

HEALTH OF SENIOR

W. VA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06252

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Alle gany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Corrigansville</u>		c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>GEPHART</u> Last <u>BOOR</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> , Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alaska RR</u>	
11. BIRTHPLACE (State or foreign country) <u>Bedford Valley, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Boor</u>		14. MOTHER'S MAIDEN NAME <u>Christina Sliger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Howard McCray, Corrigansville, Penna.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous Cell Carcinoma</u> <u>191.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 Aug</u> , 19 <u>60</u> , to <u>18 June</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>17 June</u> , 19 <u>61</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James G. Stegmaier</u>		22b. DATE SIGNED <u>6/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Stegmaier, M.D.</u>		22d. ADDRESS <u>122 S. Centre Street, Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fellowship Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Centerville, Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 22 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

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CENTRAL DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06253

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 3 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 318 Grand Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MINNIE Middle JANE Last CATLETT				4. DATE OF DEATH Month June 7, Day 19 Year 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24, 1877	
9. AGE (In years lost birthday) 84 yrs.		10. AGE UNDER 1 YEAR Months 8 Days 4 Hours 15 Min.		11. AGE UNDER 24 HRS. Months 8 Days 4 Hours 15 Min.		12. AGE UNDER 24 HRS. Months 8 Days 4 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home			
11. BIRTHPLACE (State or foreign country) Green Ridge, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Enis Robertson				14. MOTHER'S MAIDEN NAME Amanda Simms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None			
17. INFORMANT Mrs. Ella Donohoe, 318 Grand Ave., Cumb., Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Thaemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis & Scurvy DUE TO (c) 8 yrs				INTERVAL BETWEEN ONSET AND DEATH 3 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Apr. 15, 1961 to June 7, 1961 , that (I) (we) last saw the deceased alive on June 7, 1961 and that death occurred at 8 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Clay E. Durrett M.D.				22b. DATE SIGNED 6/9/61			
22c. PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.				22d. ADDRESS 236 Virginia Avenue, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 11, 1961			
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery				23d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR June 13 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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THE DEPARTMENT OF HEALTH
OFFICE OF THE SECRETARY
WASHINGTON, D. C.
JANUARY 1, 1911
MEMORANDUM FOR THE SECRETARY
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum detailing a report or recommendation.]

(1)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6270

06254

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL CUMBERLAND, MD.				d. STREET ADDRESS 1 HINKLE ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FREDRICK Middle G. Last CHAMBERLAIN				4. DATE OF DEATH Month JUNE Day 4 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-20-1879	
9. AGE (In years last bith day) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (County & State, or foreign country) NEW JERSEY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES CHAMBERLAIN				14. MOTHER'S MAIDEN NAME CHRISTINA SWEENEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. 232 - 32-7375			
17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 163X DUE TO Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 10 days 1 yr.?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Winter, 1961 to 6/4/61 , 19..., that (I) (we) last saw the deceased alive on June 4 1961 , and that death occurred at 12:20 PM from the causes and on the date stated above.							
22a. SIGNATURE Thomas L. Lusby				M.D.		22b. DATE SIGNED 6/5/61	
22c. PHYSICIAN'S NAME (Type) DR. LUSBY				22d. ADDRESS 125 Bedford, Cumberland, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/6/61		23c. NAME OF CEMETERY OR CREMATORY Piney Grove Cemetery		23d. LOCATION (City, town or county) (State) Piney Grove Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR DATE JUN 7 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

1933

1933

WILLIAM

MARYLAND

ALLIANCE

CUMBERLAND, MARYLAND

2 DAYS

CUMBERLAND, MARYLAND

MEMORIAL HOSPITAL CUMBERLAND, MD.

HUNTER ROAD

PROBABLE

CHAMBERLAIN

JUNE 1

1931

MALE

WHITE

1931

8-20-1931

1931

RETIRED

1931

NEW JERSEY

U.S.A.

JAMES CHAMBERLAIN

CHRISTIAN SWEENEY

228 - 35-378 MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

(1)

DR. LUSBY

1144 Grove Cemetery

1144 Grove Cemetery

Cumbersland Maryland

Cumbersland Maryland

may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

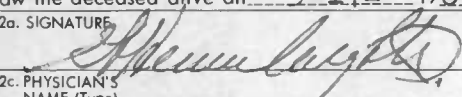

The deputy medical officer gave permission to sign this certificate at 3:45 p.m. on 6-15-61

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6271

06255

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112½ West Main Street				d. STREET ADDRESS 112½ West Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle IRENE Last CLARK				4. DATE OF DEATH Month June Day 15 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1913	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Manuel				14. MOTHER'S MAIDEN NAME Izor Kline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas Lillard, Frostburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary occlusion 451 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dissecting aneurysm thoracic aorta DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Minutes 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic hypertensive cardiovascular disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-28- 1955 to 5-17- 1961 that (I) (we) last saw the deceased alive on 5-17- 1961 , and that death occurred at 1 p.m. from the causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-16-61	
22c. PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D.				22d. ADDRESS 133 Virginia Avenue, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/18/61		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR JUN 19 '61		25b. REGISTRAR'S SIGNATURE 	

BP

1933

CERTIFICATE OF DEATH

1933



Blank form with faint horizontal lines and a large signature in the center.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6272											
CERTIFICATE OF DEATH											
06256											
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 9 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE MARYLAND f. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 349 BEDFORD STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) THOMAS			First A			Middle DARR			Last 6		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 12, 1893		9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor Of B&O Back Shops				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALLEN H. DARR						14. MOTHER'S MAIDEN NAME MARY ELLEN COOKERLY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. 216-14-1395					
17. INFORMANT W. I.						Address MEMORIAL HOSPITAL CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Sept Body 180X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5/7/61				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland City			
21. I certify that (I) (this hospital) attended the deceased from 5/7/61 to 6/6/61 , that (I) (we) last saw the deceased alive on 6/1/61 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE R.J. Williams 22c. PHYSICIAN'S NAME (Type) R.J. WILLIAMS						22b. DATE SIGNED 6/6/61 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/9/61				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				Cumberland Maryland				25a. REC'D BY REGISTRAR DATE JUN 8 '61			
								25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

(M)

2573

00326

ALLEGANY

MARYLAND

ALLEGANY

CHESBROUGH

3 DAYS

CHESBROUGH

305 BEDFORD STREET

MEMORIAL HOSPITAL
CHESBROUGH & WAINWICK AVES.

THOMAS

A

DARR

JUNE

61

WHITE

MALE

JANUARY 15, 1903

68

MARYLAND

ALLEGANY

MARY ELLEN COOKERY

ALLEN H. DARR

MEMORIAL HOSPITAL
CHESBROUGH, MD.

NO. 1

(I)

155 S. CENTRE ST., CHESBROUGH, MD.

R. J. WILLIAMS

CHESBROUGH

CHESBROUGH

CHESBROUGH

CHESBROUGH

CHESBROUGH

CHESBROUGH

1
FOR STATE
HEALTH DEPT. M

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the County Health Officer or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. To execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6273

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06257

Items 13 & 14 Film G288

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 402 Goethe Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 44 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 402 Goethe Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Walter Scott Diehl			4. DATE OF DEATH June 11, 1961			5. SEX Male		
6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12-4-90		
9. AGE (In years last birthday) 70 yrs.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O Employee-retired Railroad			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Chaneyville, Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Jacob Diehl		
14. MOTHER'S MAIDEN NAME Barnard Diehl			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 705-07-9617		
17. INFORMANT Margaret (Petterson) Diehl			18. ADDRESS 402 Goethe Street, Cumberland, Maryland			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (a), stating the underlying cause last. DUE TO (c) Sudden								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 2:00 p.m. June 11, 1961			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Benedict Skitarelic			M.D. Dr. Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF June 14, 1961			22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		
23. FUNERAL DIRECTOR Ruth E. Silcox			ADDRESS Cumberland Maryland			24a. REC'D BY REGISTRAR June 14 '61		
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			DATE June 14 '61					

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
Sudden

DATE SIGNED
June 11, 1961
Cumberland, Md.

06833

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2373

(M)

(I)

Corey, 21 years

Corey, 21 years

Corey, 21 years

Corey, 21 years

Corey, 21 years

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Corey, 21 years

Corey, 21 years

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06258

6274

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRINGFIELD d. STREET ADDRESS 85X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VIRGIL B. DYER			4. DATE OF DEATH Month Day Year JUNE 18, 19 61				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) HAMPSHIRE CO., W. VA.		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME JAMES E. DYER				
14. MOTHER'S MAIDEN NAME MATILDA DAVIS			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Diabetes Mellitus, Conditions, if any, which gave rise to immediate cause (b) virus infection (c) 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 1 week 3 days					INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week 3 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) SPRINGFIELD	(County) HAMPSHIRE	(State) W. VA.		
21. I certify that (I) (this hospital) attended the deceased from 3:35 A.M. to 6/18/61 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 6/18/61 , from the causes and on the date stated above.							
22a. SIGNATURE Dr. Blane Schindler M.D.			22b. DATE 6/18/61				
22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER			22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF June 20, 1961	23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City, town or county) (State) Fort Ashby W. Va.		
24. FUNERAL DIRECTOR'S SIGNATURE John H. Hoffer			25a. REC'D BY REGISTRAR JUN 22 '61				
25b. REGISTRAR'S SIGNATURE Arthur L. Hanes							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

00330

WILMINGTON

WEST VIRGINIA

ALLIANCE

SPRINGFIELD

2 DAYS

CONVENTION

MEMORIAL & VETERAN
MEMORIAL HOSPITAL

10

JUNE 18

DIED

5

VIRGINIA

63

0-02-1038

WHITE

MALE

U. S. A.

WILMINGTON CO., W. VA.

WATSON DAVIS

JAMES E. DAVIS

MEMORIAL HOSPITAL - CONVENTION, VIRGINIA

James E. Davis
Watson Davis

3:47 PM

13 GREEN ST., CONVENTION, VA.

DR. BLAIR SCHROEDER

James E. Davis
Watson Davis
James E. Davis
Watson Davis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06259

1. PLACE OF DEATH e. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALLEGANY CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 632 N. MECHANIC STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN FRANKLIN EASTON		4. DATE OF DEATH Month 6 Day 4 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-04
9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR: Months 6 Days 4 IF UNDER 24 HRS.: Hours 19 Min. 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mattress Builder Mattress Co 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME EUGENE EASTON (DECEASED)		14. MOTHER'S MAIDEN NAME CORA NORRIS EASTON (DECEASED)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 218-16-4140 17. INFORMANT Mrs. Frances George Cumb. Md Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Portial Embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from 6-18 , 19 58 , to 6-4 , 19 58 , that (I) (we) last saw the deceased alive on 6-4 , 19 58 , and that death occurred at 6-4 M, from the causes and on the date stated above.			
22a. SIGNATURE William F. James M.D.		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) W. P. JAMES MD		22d. ADDRESS 441 N. CENTER ST. CUMBERLAND, MD	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	23b. DATE THEREOF 6/7/61	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md		25a. REC'D BY REGISTRAR JUN 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6276

06260

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND c. LENGTH OF STAY IN 1b 27 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND d. STREET ADDRESS 612 SHRIVER AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) EDA		First L.		Middle EHRBAR		Last JUNE		Day 12		Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-1887		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN DEHLER				14. MOTHER'S MAIDEN NAME SOPHIE HOLZSHU									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD				Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X DUE TO Hypertensive arteriosclerosis Conditions, if any which gave rise to immediate cause (b) Cardiovascular disease DUE TO White P. Pulmonary embolism (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I												INTERVAL BETWEEN ONSET AND DEATH First seen 5/15/43	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		Month, Day, Year 5-15-43		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CUMBERLAND		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-15-43 to 6-12-61 , that (I) was last saw the deceased alive on 6-12-61 , and that death occurred at 8:10 P.M. the causes and on the date stated above.													
22a. SIGNATURE W. F. Williams				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
Burial		6/15/61		St. Lukes Cem.		Cumberland Md							
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md				ADDRESS				25a. REC'D BY REGISTRAR DATE JUN 15 '61		25b. REGISTRAR'S SIGNATURE Charles S. Frank			

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CUMBERLAND, MARYLAND

ST. DAVIDS

CUMBERLAND, MARYLAND

615 CHURCH AVE.

MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVE.

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MARYLAND

20711E HOLDS

JOHN DEHLER

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MEMORIAL HOSPITAL, CUMBERLAND, MD

Handwritten notes:
Cumberland, Maryland
St. David's
Cumberland, Maryland

3-12-57 6-12-57

Handwritten signature:
W. F. Williams

155 S. CENTRE ST., CUMBERLAND, MD

DR. W. F. WILLIAMS

Handwritten notes:
Cumberland, Maryland
St. David's
Cumberland, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6277

CERTIFICATE OF DEATH

Reg. Dist. No. **06261**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 681 Fayette St.				d. STREET ADDRESS 681 Fayette St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Dewey Evans				4. DATE OF DEATH Month June Day 18 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1898		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Elk Garden, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abraham Evans				14. MOTHER'S MAIDEN NAME Minnie Schell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-4848		17. INFORMANT Mrs. George Evans, 681 Fayette St. Cumb.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Corny Thrombosis 416X DUE TO Phenothiazine Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH a few hours years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1961 to June 18, 1961 , that I last saw the deceased alive on June 15, 1961 and that death occurred at 9:45 A-M , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler M.D.				ADDRESS (Street, city or town, state) 43 Greene St. Cumberland, Md. DATE SIGNED 6/18/61			
PHYSICIAN'S NAME (Type) Blaine Schindler M. D.				43 Greene St. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/61		22c. NAME OF CEMETERY OR CREMATORY Harvey Cemetery		22d. LOCATION (City, town, or county) (State) Kitzmillers, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE JUN 21 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06262**

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (Rural)			c. LENGTH OF STAY IN 1b 50 Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (Rural) Christie Road							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Christie Road				d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Zella Lolita Fisher				4. DATE OF DEATH Month Day Year June 1 19 61									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 20, 1879		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (State or foreign country) Penna				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hanson Dicken						14. MOTHER'S MAIDEN NAME Lavina Ash							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Howard Fisher				Address Christie Road, Cumberland Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (b) _____ DUE TO (c) _____ </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH SUDDEN ----- </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.													
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED				
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 1, 1961				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1961		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				22d. LOCATION (City, town, or county) (State) Cumberland Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox						ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DATE JUN 5 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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 MARYLAND-STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

06263

6279

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Franks Last Franks		4. DATE OF DEATH Month June Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1882
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Barton, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jackson Ryan		14. MOTHER'S MAIDEN NAME Mary E. Shingleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. John W. Marshall		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) stroke 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) H.C.V.D.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 1 yr 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 9, 1961 to June 20, 1961 , that (I) (we) last saw the deceased alive on June 20, 1961 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. B. Davis		22b. DATE SIGNED June 20, 1961	
22c. PHYSICIAN'S NAME (Type) John B. Davis		22d. ADDRESS Frostburg, Md. 6/20/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/23/61	
23c. NAME OF CEMETERY OR CREMATORY Bloomington Cemetery		23d. LOCATION (City, town, or county) (State) Bloomington, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25a. REC'D BY REGISTRAR JUN 26 '61	
ADDRESS Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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STATE OF TEXAS

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County of ...
State of Texas
I, the undersigned, Clerk of the County of ...
do hereby certify that the within and foregoing is a true and correct copy of the ...
as the same appears from the records of the County of ...
this 1st day of April, 1900.
Clerk of the County of ...

1

Witness my hand and the seal of the County of ...
this 1st day of April, 1900.
Clerk of the County of ...
George ...
County of ...
State of Texas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6280

06264

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 38da, 19hr, 25min d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hosp.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 238 HUMBERT ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES JOSEPH FREELAND				4. DATE OF DEATH Month Day Year 6 18 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-2-81		9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POTOMAC EDISON				10b. KIND OF BUSINESS OR INDUSTRY ELECTRIC POWER Co.		11. BIRTHPLACE (County & State, or foreign country) MD. MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME WILLIAM (D) Bookkeeper				14. MOTHER'S MAIDEN NAME Joan Hillebrandt (D)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. 217-10-9363		17. INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Uremia DUE TO (b) Myocardial Degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Hypertensive Cardio-Vascular Disease								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 12, 1961 to June 18, 1961 , that (I) (we) last saw the deceased alive on June 18, 1961 , and that death occurred at 2:37 PM , from the causes and on the date stated above.									
22a. SIGNATURE Leo H. Ley Jr.				22b. DATE SIGNED 6/23/61		22c. PHYSICIAN'S NAME (Type) LEO H. LEY JR., M.D.			
22d. ADDRESS 456 N. CENTRE ST. CUMBERLAND, MD.				22e. REC'D BY REGISTRAR JUN 27 '61					
22f. REGISTRAR'S SIGNATURE Arthur S. Kraus				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 6-22-61		23c. NAME OF CEMETERY OR CREMATORY St Mary Cem.		23d. LOCATION (City, town or county) Cumberland, Md.		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4580

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
6281
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06265

1. PLACE OF DEATH o. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		MARYLAND c. LENGTH OF STAY IN 1b 5 hours		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meyersdale d. STREET ADDRESS RD#4 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Jacob Frizzell		4. DATE OF DEATH Month Day Year June 21, 1961 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1908	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Hazelwood Construction		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Calrk Frizzell			
14. MOTHER'S MAIDEN NAME Anna Katherine Haupt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-05-7352		17. INFORMANT Meyersdale, Pa. RD#4 Mrs. Eva. M. Hesse Frizzell			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/21 19 61 , to 6/21 19 61 , that (I) (we) last saw the deceased alive on 6/21 19 61 , and that death occurred at 8:20 M, from the causes and on the date stated above.					
22a. SIGNATURE Leo H. Ley Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/28/61	
22c. PHYSICIAN'S NAME (Type) LEO H. LEY JR.		22d. ADDRESS 456 N. Centre St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1961		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens	
23d. LOCATION (City, town, or county) (State) Cumberland, Md.		RD 1			
24. FUNERAL DIRECTOR'S SIGNATURE Lawrence H. Heigler		ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE JUN 26 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6282

06266

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 70 Minutes			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			e. STREET ADDRESS Rawlings Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Joseph Robert Galliher			4. DATE OF DEATH Month June Day 5 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1912		9. AGE (In years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Rwy.		11. BIRTHPLACE (State or foreign country) Doe Gully, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Elias R. Galliher		
14. MOTHER'S MAIDEN NAME Florence V. Thompson			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W. W. 2		
16. SOCIAL SECURITY NO. 212-12-8522			17. INFORMANT Address Joseph R. Galliher, Baltimore, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock; Intraabdominal Hemorrhage, Marked DUE TO Conditions, if any, which gave rise to immediate cause (b) Stab wound of Liver (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Was stabbed in abdomen					INTERVAL BETWEEN ONSET AND DEATH about 90 Minutes. 11
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Was stabbed in abdomen			
20c. TIME OF INJURY Month, Day, Year 8:00 p. m. June 5 1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Rawlings		(County) Allegany		(State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6/8/61		
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.			24a. REC'D BY REGISTRAR June 9 '61		
24b. REGISTRAR'S SIGNATURE Charles S. Harris			DATE JUN 9 '61		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03266

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03266

FOR STATE
HEALTH DEPT.

1

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Date of Death: _____

6. Place of Death: _____

7. Cause of Death: _____

8. Manner of Death: _____

9. Signature of Medical Examiner: _____

10. Date of Signature: _____

11. Signature of Coroner: _____

12. Date of Signature: _____

13. Signature of Physician: _____

14. Date of Signature: _____

15. Signature of Nurse: _____

16. Date of Signature: _____

17. Signature of Pathologist: _____

18. Date of Signature: _____

19. Signature of Forensic Scientist: _____

20. Date of Signature: _____

21. Signature of Toxicologist: _____

22. Date of Signature: _____

23. Signature of Anthropologist: _____

24. Date of Signature: _____

25. Signature of Radiologist: _____

26. Date of Signature: _____

27. Signature of Entomologist: _____

28. Date of Signature: _____

29. Signature of Microscopist: _____

30. Date of Signature: _____

31. Signature of Chemist: _____

32. Date of Signature: _____

33. Signature of Biologist: _____

34. Date of Signature: _____

35. Signature of Geologist: _____

36. Date of Signature: _____

37. Signature of Astronomer: _____

38. Date of Signature: _____

39. Signature of Meteorologist: _____

40. Date of Signature: _____

41. Signature of Oceanographer: _____

42. Date of Signature: _____

43. Signature of Climatologist: _____

44. Date of Signature: _____

45. Signature of Environmental Scientist: _____

46. Date of Signature: _____

47. Signature of Public Health Officer: _____

48. Date of Signature: _____

49. Signature of Health Commissioner: _____

50. Date of Signature: _____

51. Signature of State Health Officer: _____

52. Date of Signature: _____

53. Signature of County Health Officer: _____

54. Date of Signature: _____

55. Signature of City Health Officer: _____

56. Date of Signature: _____

57. Signature of Town Health Officer: _____

58. Date of Signature: _____

59. Signature of Village Health Officer: _____

60. Date of Signature: _____

61. Signature of Ward Health Officer: _____

62. Date of Signature: _____

63. Signature of Precinct Health Officer: _____

64. Date of Signature: _____

65. Signature of Block Health Officer: _____

66. Date of Signature: _____

67. Signature of Street Health Officer: _____

68. Date of Signature: _____

69. Signature of Alley Health Officer: _____

70. Date of Signature: _____

71. Signature of Lane Health Officer: _____

72. Date of Signature: _____

73. Signature of Court Health Officer: _____

74. Date of Signature: _____

75. Signature of Square Health Officer: _____

76. Date of Signature: _____

77. Signature of Park Health Officer: _____

78. Date of Signature: _____

79. Signature of Plaza Health Officer: _____

80. Date of Signature: _____

81. Signature of Garden Health Officer: _____

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83. Signature of Field Health Officer: _____

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85. Signature of Meadow Health Officer: _____

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87. Signature of Pasture Health Officer: _____

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89. Signature of Woodland Health Officer: _____

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91. Signature of Forest Health Officer: _____

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93. Signature of Swamp Health Officer: _____

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95. Signature of Marsh Health Officer: _____

96. Date of Signature: _____

97. Signature of Bay Health Officer: _____

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99. Signature of Sound Health Officer: _____

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101. Signature of Strait Health Officer: _____

102. Date of Signature: _____

103. Signature of Trench Health Officer: _____

104. Date of Signature: _____

105. Signature of Harbor Health Officer: _____

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107. Signature of Port Health Officer: _____

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109. Signature of Canal Health Officer: _____

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111. Signature of River Health Officer: _____

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113. Signature of Stream Health Officer: _____

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115. Signature of Brook Health Officer: _____

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117. Signature of Creek Health Officer: _____

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119. Signature of Lake Health Officer: _____

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121. Signature of Pond Health Officer: _____

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123. Signature of Reservoir Health Officer: _____

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125. Signature of Dam Health Officer: _____

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127. Signature of堰 Health Officer: _____

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129. Signature of Weir Health Officer: _____

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131. Signature of Sluice Health Officer: _____

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133. Signature of Lock Health Officer: _____

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135. Signature of Bridge Health Officer: _____

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137. Signature of Tunnel Health Officer: _____

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139. Signature of Viaduct Health Officer: _____

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141. Signature of Causeway Health Officer: _____

142. Date of Signature: _____

143. Signature of Embankment Health Officer: _____

144. Date of Signature: _____

145. Signature of Cut Health Officer: _____

146. Date of Signature: _____

147. Signature of Filling Health Officer: _____

148. Date of Signature: _____

149. Signature of Excavation Health Officer: _____

150. Date of Signature: _____

151. Signature of Foundation Health Officer: _____

152. Date of Signature: _____

153. Signature of Structure Health Officer: _____

154. Date of Signature: _____

155. Signature of Building Health Officer: _____

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157. Signature of House Health Officer: _____

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159. Signature of Shop Health Officer: _____

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161. Signature of Office Health Officer: _____

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163. Signature of Factory Health Officer: _____

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165. Signature of Warehouse Health Officer: _____

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167. Signature of Store Health Officer: _____

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169. Signature of Bank Health Officer: _____

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171. Signature of School Health Officer: _____

172. Date of Signature: _____

173. Signature of Church Health Officer: _____

174. Date of Signature: _____

175. Signature of Hall Health Officer: _____

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177. Signature of Theater Health Officer: _____

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179. Signature of Arena Health Officer: _____

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181. Signature of Stadium Health Officer: _____

182. Date of Signature: _____

183. Signature of Coliseum Health Officer: _____

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185. Signature of Amphitheater Health Officer: _____

186. Date of Signature: _____

187. Signature of Circus Health Officer: _____

188. Date of Signature: _____

189. Signature of Fair Health Officer: _____

190. Date of Signature: _____

191. Signature of Festival Health Officer: _____

192. Date of Signature: _____

193. Signature of Fairground Health Officer: _____

194. Date of Signature: _____

195. Signature of Race Track Health Officer: _____

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197. Signature of Casino Health Officer: _____

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199. Signature of Club Health Officer: _____

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201. Signature of Casino Health Officer: _____

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299. Signature of Casino Health Officer: _____

300. Date of Signature: _____

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6283

CERTIFICATE OF DEATH

06267

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 hr. 25 mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND RURAL			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART				d. STREET ADDRESS CASH VALLEY ROAD			
3. NAME OF DECEASED (Type or print) First Middle Last AMEL D. GANO				4. DATE OF DEATH Month Day Year 6 15 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6/13/07		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 54 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B&O RAILROAD GERMAN		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA			
12. CITIZEN OF WHAT COUNTRY? UNITED STATES				13. FATHER'S NAME JOHN (D) GANO			
14. MOTHER'S MAIDEN NAME BELLE (D) ?				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I			
16. SOCIAL SECURITY NO. 705 07 9670				17. INFORMANT CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 <i>Brachyogenic Carcinoma</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from October, 1960 to 15 June, 1961 , that (I) (we) last saw the deceased alive on 15 June 1961 , and that death occurred at 12:55 PM , from the causes and on the date stated above.							
22a. SIGNATURE L. Michael Glick M.D.				22b. DATE SIGNED October 15, 1961			
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK, M.D.				22d. ADDRESS 126 N. SMALLWOOD ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			
23d. LOCATION (City, town or county) (State) Cumberland, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				25a. REC'D BY REGISTRAR JUN 20 '61			
ADDRESS Cumberland, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

00583

00583

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH										06268	
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 17 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS RT. #1 Cash Valley Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last ISABELLA LOUISE GETSON						4. DATE OF DEATH Month Day Year JUNE 14 1961					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 17, 1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK BROWN						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fibrosis DUE TO (c) Coronary arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 30 days ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aneurysm aorta											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 19 61 to June 14 19 61 , that (I) (we) last saw the deceased alive on June 13 19 61 , and that death occurred at 7:15 AM , from the causes and on the date stated above.											
22a. SIGNATURE Samuel M. Jacobson						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/14/61			
22c. PHYSICIAN'S NAME (Type) SAMUEL M. JACOBSON						22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/17/61		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.			
24 FUNERAL DIRECTOR'S SIGNATURE H. Wayne George,						ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

00383

0284

M

ALLEGANY

MARYLAND

MARYLAND

MARYLAND

17 DAYS

MARYLAND

MEMORIAL HOSPITAL
MEMORIAL & MARWICK AVENUE

RT. 51

ISABELLA

DETSON

JUNE 11

FEMALE WHITE

MARYLAND

FRANK BROWN

I

MARYLAND, MD.

MEMORIAL HOSPITAL

WOMEN

NO

ORIGINAL RECORD

ORIGINAL RECORD

ORIGINAL RECORD

ORIGINAL RECORD

7:15 AM

SAMUEL M. JACKSON

50 PERSHING ST., CUMBERLAND, MD.

Commander, Cemetery, Cumberland, Md.

6/17/71

Cumbers, Md.

Wayne County, Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06269

1. PLACE OF DEATH a. COUNTY ALLEGANY b. STATE MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. LENGTH OF STAY IN 1b 16 HRS. 17 MIN. e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL f. STREET ADDRESS JACKSON HILL g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES ELMER GETSON, JR.		4. DATE OF DEATH Month JUNE Day 10 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 9, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND
13. FATHER'S NAME JAMES E. GETSON		14. MOTHER'S MAIDEN NAME SALLY ANN ARMSTRONG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO remotely Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 9, 1961 , to June 10, 1961 , that (I) (we) last saw the deceased alive on June 10, 1961 , and that death occurred 12:35 PM from the causes and on the date stated above.			
22a. SIGNATURE W. Royce Hodges M.D.		22b. DATE SIGNED JUN 10 1961	
22c. PHYSICIAN'S NAME (Type) W. ROYCE HODGES		22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/11/1961	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town or county) (State) Lonaconing, MD.
24 FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		25a. REC'D BY REGISTRAR JUN 15 61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Brown</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

2060182XV2

06282

ALLEGANY

MARYLAND

ALLEGANY

16 HRS. 17 MIN. REMAINING

CUMBERLAND

JACKSON HILL

MEMORIAL HOSPITAL
JACKSON & WARRICK AVES.

JUNE 10 61

ETSON, JR.

JAMES

JUNE 9, 1961

WHITE

MALE

17

U.S.A.

CUMBERLAND, MARYLAND

SALLY ANN ARMSTRONG

JAMES E. ETSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

152 SOUTH CENTRE ST., CUMBERLAND, MD.

M. BOYLE HOUSE

Ironwood, MD.

Oak Hill Cemetery

1001 1st St.

IRONWOOD, MD.

GEORGE RICHMAN

M

C

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6286

CERTIFICATE OF DEATH

Reg. Dist. No. 06270

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b X Mt. Savage. XXXXXX			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Sunnyside			
3. NAME OF DECEASED (Type or print) First Virginia Middle Leona Last Gordon				4. DATE OF DEATH Month June Day 1 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1908		9. AGE (In years lost birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile wrkr		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Imes				14. MOTHER'S MAIDEN NAME Rebecca Wingfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Walter Gordon, Mt. Savage, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Involvement of all abdominal viscera DUE TO (c) Carcinoma of Right Colon. INTERVAL BETWEEN ONSET AND DEATH 5 MOS. 19 MOS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Surgery 1/5/59, Rt. Colectomy; 7/29/60 Colostomy, Excision of Sigmoid 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 3, 1959 , to June 1, 1961 , that I last saw the deceased alive on June 1, 1961 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Alvin J. Walters M.D.				ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md.			
DATE SIGNED 6/3/61							
PHYSICIAN'S NAME (Type) Alvin Walters M. D.		Frostburg, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Savage Meth. Cem.		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George,				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 5 '61	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kneass			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
6287
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06271

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 623 Henderson Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Thomas Last Griminger		4. DATE OF DEATH Month June Day 24 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1886
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel E. Griminger		14. MOTHER'S MAIDEN NAME Mary Manley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. S38996	
17. INFORMANT Mrs. Grace Griminger		623 Henderson Avenue, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) ASHD		INTERVAL BETWEEN ONSET AND DEATH 9 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/6/60 19 to 6/24 19 61 , that (I) (we) lost saw the deceased alive on 6/6/61 , and that death occurred at 8:00 P. M, from the causes and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED 6-26-61	
22c. PHYSICIAN'S NAME (Type) WILLIAM P. JAMES, M.D.		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 27, 1961	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR DATE JUN 28 '61	
ADDRESS Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

06271

CERTIFICATE OF DEATH

028

(M)

(T)

Blank lines for text entry, including fields for name, date, and location.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6288

06272

1. PLACE OF DEATH e. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 10 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 231 AVIRETT AVENUE								
3. NAME OF DECEASED (Type or print) SARAH Catherine MCCULLEY		4. DATE OF DEATH Month JUNE Day 10 Year 19 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1870	9. AGE (In years last birthday) 90 yrs. <table border="1" style="display: inline-table; font-size: 8pt;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Months	Days	Hours	Min.									
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND								
12. CITIZEN OF WHAT COUNTRY? U.S.A.												
13. FATHER'S NAME JAMES MCCULLEY (D)			14. MOTHER'S MAIDEN NAME RACHAEL ? Ruby									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UNKNOWN No		16. SOCIAL SECURITY NO. None		17. INFORMANT CHART								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (e), stating the underlying cause last.												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour e.m. _____ p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____												
21. I certify that (I) (this hospital) attended the deceased from 5/31, 1961 to 6/10, 1961, that (I) (we) last saw the deceased alive on 6/10, 1961, and that death occurred at 6:30 PM, from the causes and on the date stated above.												
22a. SIGNATURE Leo H. Key Jr. M.D.			22b. DATE SIGNED 6/11/61									
22c. PHYSICIAN'S NAME (Type) LEO H. KEY JR., M.D.			22d. ADDRESS 456 N. Centre St. Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/61		23c. NAME OF CEMETERY OR CREMATORY Oldtown Methodist Cem.								
23d. LOCATION (City, town or county) Oldtown, Maryland												
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.			25a. REC'D BY REGISTRAR JUN 16 1961									
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas												

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

0023

0023

M

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

10 DAYS

CUMBERLAND

SACRED HEART HOSPITAL

231 AVENUE

SARAH

Early morning

JUNE 10 1921

FEMALE WHITE

KIX

11-27-1920

90

Non-painful

Cardiac

MARYLAND

U.S.A.

JAMES MCCULLY (D)

RACHAEL

Infant

CHART

None

Unusual to

I

1920 P. M. 11. H. D.

OS. Town Hospital, Ga.

1920/12/01

John J. White, Cumberland, Md.

July 1921

Office, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6289

CERTIFICATE OF DEATH

06273

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 6 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 106 SPRINGDALE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCIS Middle B. Last HARRIS		4. DATE OF DEATH Month JUNE Day 7 Year 1961					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 8, 1890	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 7 Days 19 Hours 61		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Catcher		10b. KIND OF BUSINESS OR INDUSTRY Tin Plate Mill		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ISAAC HARRIS				14. MOTHER'S MAIDEN NAME HANNAH O'LEARY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. I69-05-4746		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto Head Block - 433.0 DUE TO (b) Posterior Nasal Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Multiple Small Stroke Syndrome due to Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from June 6, 1961, 3:38 A.M. to June 6, 1961, that (I) (we) last saw the deceased alive on June 6, 1961, and that death occurred at 3:38 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 6/7/61					
22c. PHYSICIAN'S NAME (Type) DR. O. G. HUMMELWRIGHT		22d. ADDRESS <i>[Signature]</i> 633 W. Ave Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-9-61		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.			
23d. LOCATION (City, town or county) Cumberland, Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUN 14 '61			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

65273

(M)

ALLEGANY

WYLAND

ALLEGANY

CUMBERLAND

CUMBERLAND

6 DAYS

MEMORIAL HOSPITAL

106 SPRINGDALE STREET

FRANCIS

HARRIS

JUNE

61

WHITE

MAY 8, 1900

71

RETIRED COLONEL

CUMBERLAND, MD.

U.S.A.

ISAAC HARRIS

HANNAH O'LEARY

100-03-1 TABERNASH HOSPITAL - CUMBERLAND, MD.

(1)

Handwritten notes:
The above is a copy of the original record of the death of Isaac Harris, who died on May 8, 1900, at the age of 71 years, of a heart attack. He was a retired colonel in the U.S. Army and was born in Cumberland, Md.

3:38 P.M. June 21

DR. C. G. HINNEMANN

Dr. C. G. Hinnemann, M.D., Cumberland, Md.

James E. Campbell, Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

6290

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06274

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural near Paw Paw, W. Va.		c. LENGTH OF STAY IN 1b years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Near Paw Paw, W. Va.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAURA Middle BEATRICE Last HARTLEY		4. DATE OF DEATH Month June Day 24 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Burlington, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Blackburn		14. MOTHER'S MAIDEN NAME Hariett Leatherman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles House, Rt. 1, Paw Paw, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arterio-sclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-23-61 19 to 6-23-61 19, that (I) (we) last saw the deceased alive on 6-23-61 19, and that death occurred any 22 PM from the causes and on the date stated above.			
22a. SIGNATURE William P. James M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 6/25/61			
22c. PHYSICIAN'S NAME (Type) WILLIAM P. JAMES, M.D.			
22d. ADDRESS 441 N. Centre Street, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/61	
23c. NAME OF CEMETERY OR CREMATORY Hartley Family Cemetery		23d. LOCATION (City, town, or county) (State) Near Paw Paw, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE JUN 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. House			



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may be obtained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6291

06275

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLDTOWN			c. LENGTH OF STAY IN lb LIFE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLDTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESIDENCE				d. STREET ADDRESS RESIDENCE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last HAUGH				4. DATE OF DEATH Month JUNE Day 24 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 3, 1875	
9. AGE (In years last birthday) 86 yrs.		10. AGE (In years last birthday) 86 yrs.		11. IF UNDER 1 YEAR Months Days Hours Min.		12. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY TIE PLANT		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME CHARLES HAUGH				14. MOTHER'S MAIDEN NAME LYDIA PIPER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 105-05-2992		17. INFORMANT DONALD HAUGH Address OLDTOWN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis. 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) General Arterio sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 21 hrs. 10-15 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 56 19 6-23-61 to 6-23-61 19 6-23-61 , that (I) (we) last saw the deceased alive on 6-23-61 19 6-23-61 , and that death occurred at 8 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>J. I. Armstrong</i> M.D.				22b. DATE SIGNED 6-24-61.		22c. PHYSICIAN'S NAME (Type) J. I. Armstrong	
22d. ADDRESS Paw Paw, W. Va.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 27, 1961		23c. NAME OF CEMETERY OR CREMATORY OLDTOWN CEMETERY		23d. LOCATION (City, town, or county) (State) OLDTOWN, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE JUN 28 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

MEDICAL CERTIFICATION

06332

CERTIFICATE OF DEATH

06332

(M)



6292

06276

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 1, Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Elsie Mae Hausrath		First Middle Last		4. DATE OF DEATH June 5th, 1961		Month Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28th, 1908	
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Opr. Down-		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Twist) Walter Simpson		14. MOTHER'S MAIDEN NAME Bella Brown		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-10-5204		17. INFORMANT Mrs. Evelyn Whorton, Rt. 1, F'bg., Box A-7		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas & Liver 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 month		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frostburg, Md.		20g. (County) Allegany		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from March 1961 to June 5, 1961 , that (I) (was) last saw the deceased alive on June 5, 1961 , and that death occurred at 1:20 PM , from the causes and on the date stated above.		22a. SIGNATURE John B. Davis,		22b. DATE SIGNED 6/6/61		22c. PHYSICIAN'S NAME (Type) John B. Davis,	
22d. ADDRESS 2 Broadway, Frostburg, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE 6/6/61		22g. SIGNATURE Arthur L. Huns	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-7-61		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. P. Duvost		24a. ADDRESS Frostburg, Md.		24b. REC'D BY REGISTRAR DATE JUN 8 '61		24c. REGISTRAR'S SIGNATURE Arthur L. Huns	

00270

CERTIFICATE OF DEATH

1902

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Proctor, J. H.

Proctor, J. H.

Proctor, J. H.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6293

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06277

1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>40 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		02	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rear of Edwards Avenue? Cumberland, M.D.</u>				d. STREET ADDRESS <u>144 INDEPENDENCE ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD EUGENE HUBBS</u>				4. DATE OF DEATH Month Day Year <u>JUNE 5 19 61</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 1, 1890</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RES. HOUSING</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WM. E. HUBBS</u>				14. MOTHER'S MAIDEN NAME <u>ROSE B. STALLINGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> WW 1		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>THOMASM C. HUBBS CUMBERLAND, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maceration of Brain, Skull Fracture</u> Sudden 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gunshot wound of Head</u> Sudden DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 8, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CUMBERLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BYRON KIGHT</u>				ADDRESS <u>CUMBERLAND, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 12 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
Item 7 Film G289 6/29/61 mb													
06278													
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <u>Allegany</u> b. COUNTY <u>Allegany</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>						c. LENGTH OF STAY IN 1b <u>10 da., 28 min. 02</u> <u>Cumberland</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sacred Heart Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Newton</u> Middle <u>Frederick</u> Last <u>Iser</u>						4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>19 61</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>WIDOWED</u>		8. DATE OF BIRTH <u>3-8-1893</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>22</u> Days <u>19</u> Hours <u>61</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired General Contractor self Emp. Three Churches W.Va.</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Robert Iser (D)</u>						14. MOTHER'S MAIDEN NAME <u>Amanda Elifritz</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>						16. SOCIAL SECURITY NO. <u>Chart</u>							
17. INFORMANT <u>Chart</u>						Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 422.2 DUE TO (b) <u>Malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Myocardial Degeneration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u>												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 13, 1961</u> , to <u>June 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 22, 1961</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.													
22a. SIGNATURE <u>Leo H. Ley, M.D.</u>						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/24/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leo H. Ley, M.D.</u>						22d. ADDRESS <u>456 N. Centre Street, Cumb., Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-26-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Abe Cemetery</u>		23d. LOCATION (City, town or county) <u>Wiley Ford, W.Va.</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>						ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

VR A15 (4)
15M 9/60

06378

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88

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W.V.

8-28-61

Abbe Cemetery

Burial

James R. Campbell

John S. Campbell

VS. A15ME
5M 7/59

06279

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)	
Allegany		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cumberland,		Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
206 Washington St.,		206 Washington St.,	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
JAMES THOMAS JOHNSON		June 21, 1961	
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 19, 1897	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Medical Dr. & Surg.		Medical	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Cumberland, Maryland		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James. T. Johnson Sr.		Ida C. Mathis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
Yes, W.W. # 1			
17. INFORMANT		Address	
Mrs. Joan M. Johnson		Cumb. Md 206 Washington St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CORONARY OCCLUSION	
4201 DUE TO		CORONARY THROMBOSIS	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b) DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 21, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		6/24/61	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Rose Hill Cemetery		Cumberland, Md.	
23. FUNERAL DIRECTOR H. Wayne George, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 26 '61	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

00353

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[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed and signed by the funeral director. After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
06280														
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND, MD. d. STREET ADDRESS 420 MARYLAND AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) FLORA			First J.			Middle JONES			Last JONES			4. DATE OF DEATH Month JUNE Day 22 Year 1961		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-1891		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 22		IF UNDER 24 HRS. Hours 19 Min. 61		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (County & State, or foreign country) PENNA. Jersey Shore U.S.A				12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME FRANK, FRY						14. MOTHER'S MAIDEN NAME Miltilda Slaughwhite								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Hypertensive Cardiac Disease causing the underlying cause last. (c) DUE TO Arteriosclerotic Hypertensive Cardiac Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Interval between onset and death 24 hrs.														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from June 1961 to June 1961 , that (I) (we) last saw the deceased alive on June 22 1961 , and that death occurred at 3:35 PM the causes and on the date stated above. 22a. SIGNATURE DR. OVERTON G. HIMMELWRIGHT M.D. 22b. DATE SIGNED 6/23/61 22c. PHYSICIAN'S NAME (Type) DR. OVERTON G. HIMMELWRIGHT 22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6-26-61			23c. NAME OF CEMETERY OR CREMATORY St Patrick Cemetery			23d. LOCATION (City, town or county) (State) Cumberland, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.						25a. REC'D BY REGISTRAR DATE JUN 27 '61			25b. REGISTRAR'S SIGNATURE Arthur G. ...					

(M)

00380

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND, MD.

1 DAY

CUMBERLAND, MD.

150 MARYLAND AVE.

MEMORIAL HOSPITAL
150 MARYLAND AVE.

DATE 01

JONES

FLORA

TO

2-2-1981

X

FLORIE WHITE

PENNA. Jersey Shore, S.A.

PHOTOGRAPH

PHOTOGRAPH

PHOTOGRAPH

PHOTOGRAPH

MEMORIAL HOSPITAL, CUMBERLAND, MD.

HOME

HOME

Handwritten notes:
Cumberland Hospital
Cumberland, Md.
2-2-1981

Handwritten notes:
2-2-1981

Handwritten notes:
2-2-1981

133 VIRGINIA AVE., CUMBERLAND, MD.

DR. EVERTON G. RINEHART

Cumberland, Md.

Cemetery

2-2-1981

Burial

James I. Beardsley, Cumberland, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the medical examiner. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06281

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9 Hrs. 27 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 933 Gay Street			
3. NAME OF DECEASED (Type or print) First RUTH Middle LEODA Last KEEFER				4. DATE OF DEATH Month June Day 12 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Bean's Cove, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Oster				14. MOTHER'S MAIDEN NAME Alberta Ruby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Joseph Wilson, Cumberland, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO CEREBRAL CONTUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 31 Hrs. 31 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Hypertrophy, marked; Hypertension						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home getting out of bed					
20c. TIME OF INJURY Month, Day, Year 5:00 June 11 1961 Hour o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 13, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 15, 1961		22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Meth. Com.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland ADDRESS				24a. REC'D BY REGISTRAR JUN 16 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

6298

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06282

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lavale		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Center Street		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Viola Selina Keenan		4. DATE OF DEATH June 13, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1876
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ohio.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Mayle		14. MOTHER'S MAIDEN NAME Evelyn Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT John Keenan		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebro-vascular Accident DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/11/61 to 6/13/61 , that (I) (we) last saw the deceased alive on 6/11/61 , and that death occurred at 2:40p. M, from the causes and on the date stated above.			
22a. SIGNATURE George M. Simons M.D.		22b. DATE SIGNED 6/14/61	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M.D.		22d. ADDRESS Algonquin Hotel, Cumberland, Md.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 6/16/1961	
23c. NAME OF CEMETERY OR CREMATORY Mayle Cemetery		23d. LOCATION (City, town, or county) (State) near Deer Park, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. S. Leighton		ADDRESS Oakland, Md.	
25a. REC'D BY REGISTRAR DATE JUN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

00222

CERTIFICATE OF MARRIAGE

00222



State of New York

Albany

County of Albany

1 year

1 year

John A. Lee

Center Street

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

John A. Lee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06283

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SACRED HEART		c. LENGTH OF STAY in 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARRELSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART Hosp.				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Cecelia KELLEY		b. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/2/01 10/2/01	
5. SEX FEMALE		6. COLOR OR RACE WHITE		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND, Mt. Savage		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JAMES LOAR (DECEASED)				14. MOTHER'S MAIDEN NAME Mary FITZPATRICK (DECEASED)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, RLL with Congestive Heart Failure DUE TO (b) Cerebral Hemorrhage, left cerebral hemisphere, from left middle cerebral artery, encapsulated DUE TO (c) Arteriosclerotic Cardiovascular Disease						INTERVAL BETWEEN ONSET AND DEATH 3 days 8 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus with mild ketosis.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from May 31, 1961, to June 7th, 1961 that (I) (we) last saw the deceased alive on June 7th, 1961, and that death occurred at 6:59 AM, from the causes and on the date stated above.							
22a. SIGNATURE Wyand A. Doerner Jr M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-8-61	
22c. PHYSICIAN'S NAME (Type) WYAND DOERNER, M.D.				22d. ADDRESS ALGONQUIN BLDG. CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/61		23c. NAME OF CEMETERY OR CREMATORY St. Patricks Cath. Cem.		23d. LOCATION (City, town or county) (State) Mt. Savage, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				25a. REC'D BY REGISTRAR JUN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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00383

M

SECRET

CONFIDENTIAL

7 days

RAHREYVILLE

Mar. land

ALBANY

ALBANY

COAST

COAST

COAST

10/3/01

X

WATER

WATER

On base

On base

JAMES L. (WATER)

JAMES L. (WATER)

WATER

WATER

WATER

3 days

Providence, R.I. with extensive heavy rain

8 days

Providence, R.I. with extensive heavy rain

10 years

Providence, R.I. with extensive heavy rain

Diabetes mellitus with mild ketosis.

10 June 50

May 50

May 50

0-0-01

X

ALBANY, N.Y. (WATER)

ALBANY, N.Y. (WATER)

ALBANY, N.Y. (WATER)

ALBANY, N.Y. (WATER)

ALBANY, N.Y. (WATER)

ALBANY, N.Y. (WATER)

ALBANY, N.Y. (WATER)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06284

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 30 Washington Street				d. STREET ADDRESS R.D. #1, Wright's Crossing			
3. NAME OF DECEASED (Type or print) NELLIE				4. DATE OF DEATH 6 22 19 61			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-26-1881	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (County & State, or foreign country) Eckhart				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Harris				14. MOTHER'S MAIDEN NAME Catherine Cross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. R. Cecil Kergan, Frostburg Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157X DUE TO (b) Metastases to Liver Kidney Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Etc			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1961 to June 22 1961 , that (I) (we) last saw the deceased alive on June 21 1961 , and that death occurred with from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane				22b. DATE SIGNED June 23 1961		22c. PHYSICIAN'S NAME (Type) W. O. McLane M.D.	
22d. ADDRESS Frostburg Md.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/61		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City, town or county) (State) Frostburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montemur				25a. REC'D BY REGISTRAR JUN 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

00284

63084

(M)

(1)

Researcher's Name: [illegible]
Address: [illegible]
City: [illegible]
State: [illegible]
Zip: [illegible]
Date: [illegible]
Subject: [illegible]
Reference: [illegible]
Notes: [illegible]

*Classification of [illegible]
Material to be [illegible]*

*For [illegible]
[illegible]
[illegible]*

Project: [illegible]
Status: [illegible]
Comments: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal (and in any event, within 72 hours after death).

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6301

06285

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 44 WEST MECHANIC		d. STREET ADDRESS 44 WEST MECHANIC	
3. NAME OF DECEASED (Type or print) First Middle Last VIRA FRYE KIGHT		4. DATE OF DEATH Month Day Year JUNE 24, 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 13/93 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY own home	9. AGE (In years last birthday) 67 yrs.
11. BIRTHPLACE (County & State, or foreign country) MONROEVILLE, OHIO		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME CLAYTON FRYE		14. MOTHER'S MAIDEN NAME SUSAN WHALEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-01-8675	
17. INFORMANT THEODORA KIGHT, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peptic Ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Rheumatoid Arthritis		INTERVAL BETWEEN ONSET AND DEATH 5 minutes? 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. X 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State) X	
21. I certify that (I) (this hospital) attended the deceased from July 4, 19 58 to 6/24, 1961 , that (I) (we) last saw the deceased alive on 6/24 , 19 61 , and that death occurred at 24 M, from the causes and on the date stated above.			
22a. SIGNATURE Martin Rothstein		22b. DATE SIGNED 6/24/61	
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/26/61	
23c. NAME OF CEMETERY OR CREMATORY PHILOPS CEMETERY		23d. LOCATION (City, town or county) (State) WESTERNPORT, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Fredlock Jr.		25. REC'D BY REGISTRAR JUN 27 '61	
ADDRESS PIEDMONT, W.VA.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MONTGOMERY, ALA. 36101

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OFFICIALS AND AGENTS, MONTGOMERY, ALA.

012-101

MARTIN R. HUSTON, M.D., 1000 10TH AVENUE, MONTGOMERY, ALA.

012-101 012-101 012-101 012-101 012-101 012-101 012-101 012-101 012-101 012-101

012-101 012-101 012-101 012-101 012-101 012-101 012-101 012-101 012-101 012-101

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6302

Reg. Dist. No. 06286

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 220 Utah Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Claude Albert Kimmell				4. DATE OF DEATH Month Day Year June 29, 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1896		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter Helper		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Thayersville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Kimmell (D)				14. MOTHER'S MAIDEN NAME Jennie Bowser (D)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 210-09-6947		17. INFORMANT Address Lenora Kimmell 220 Utah Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH SUDDEN ----	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 29, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-61		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				24a. REC'D BY REGISTRAR JUL 3 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Brand</i>	

DATE SIGNED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

62286

102

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
JAMES J. KELLEY		45		Male		Caucasian		1945		Boston, Mass.	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Medical Examiner	
100 North Street		Carpenter		Heart Disease		Natural		10:00 AM		J. J. Kelley	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Autopsy		Signature of Coroner	
1900		Boston, Mass.		1945		1945		1945		J. J. Kelley	
Date of Death		Place of Death		Date of Burial		Place of Burial		Date of Interment		Signature of Minister	
1945		Boston, Mass.		1945		Boston, Mass.		1945		J. J. Kelley	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6303

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06287

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>15 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>443 Race Street</u>				d. STREET ADDRESS <u>443 Race Street</u>			
3. NAME OF DECEASED (Type or print) First <u>GARRETT</u> Middle <u>LUTMAN</u> Last <u>KINSER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1891</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Flintstone, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE KINSER</u>				14. MOTHER'S MAIDEN NAME <u>MARY CUNROD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Richard Kinser, Rt. #3, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/14/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Meth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Oldtown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUN 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Richard S. Kinser</u>	

DATE SIGNED

6/12/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06288

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 15 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Delbert Raymond Kitzmiller		4. DATE OF DEATH June 25 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1894
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Kitzmiller		14. MOTHER'S MAIDEN NAME Ida Rosenmerkle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-057-397	
17. INFORMANT Mrs. Delbert Kitzmiller,		Address Cumb. Md. 701 Washington	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 - 16, 1960 , to 6 - 25, 1961 , that I last saw the deceased alive on 6 - 25, 1961 , and that death occurred at 9p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		DATE SIGNED 6-27-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 28, 1961	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George,		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 29 '61		24b. REGISTRAR'S SIGNATURE Charles L. George	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6306

CERTIFICATE OF DEATH

06290

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 30 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND ALLEGANY
b. COUNTY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. STREET ADDRESS 16 BALTIMORE ST.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EMMA R. LENHART
First Middle Last
5. SEX FEMALE 6. COLOR OR RACE WHITE
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-13-84
9. AGE (In years last birthday) 76
IF UNDER 1 YEAR Months Days IF UNDER 27 HRS. Hours Min. | | 4. DATE OF DEATH 6 6 1961
Month Day Year
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 13. FATHER'S NAME GEORGE LOGSDON (DECEASED)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT CHART
Address | | 14. MOTHER'S MAIDEN NAME HATTIE AIMER LOGSDON (DECEASED)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic heart disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) generalized arteriosclerosis
(a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 3-4 1960 to 6-6 1961 , that (I) (we) last saw the deceased alive on 6-6 1961 , and that death occurred at 8:30 PM , from the causes and on the date stated above.
22a. SIGNATURE 22b. DATE SIGNED 6-7-61
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS 57 GREENE ST. CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 6-10-61
23c. NAME OF CEMETERY OR CREMATORY Cooks Mills Cemetery
23d. LOCATION (City, town or county) Hyndman RD#1 Pa. | | 24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler
ADDRESS Hyndman Pa.
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur S. Hines
DATE JUN 12 '61 | |

00230

6506

(M)

ALBANY

HARTLAND

ALBANY

COMMITTEE TO

30 days

COMMITTEE TO

16 JAILHOUSE ST.

16 JAILHOUSE ST.

1 JAILHOUSE ST.

R.

2-10-51

78

7-10-51

WHITE

WHITE

UNITED STATES

Pennsylvania

WATER ALICE JOHNSON (US 242)

UNITED STATES (US 242)

(I)

CLARK

27 GREEN ST. CHICAGO, ILL.

27 GREEN ST. CHICAGO, ILL.

Pa.

COOK'S 1115 GARDEN HYDRAULIC

6-10-51

Hospital

Handwritten signature/initials

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 1 Film G289

6/22/61 iwk

06291

1. PLACE OF DEATH

a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, give nearest town)

c. LENGTH OF STAY IN lb

La Vale Md.

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

La Vale Sacred Heart Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

e. STATE

b. COUNTY

MARYLAND

ALLEGANY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

LA VALE

d. STREET ADDRESS

68 NATIONAL HIGHWAY

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

JOSEPH

RICHARD

LOGSDON

4. DATE OF DEATH

Month

Day

Year

6

15

19 61

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED

☒ NEVER MARRIED ☐

B. DATE OF BIRTH

May 20, 1916

9. AGE (In years last birthday)

45 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Bus Driver

10b. KIND OF BUSINESS OR INDUSTRY

City Bus

11. BIRTHPLACE (County & State, or foreign country)

Cumberland Md.

12. CITIZEN OF WHAT COUNTRY?

UNITED STATES

13. FATHER'S NAME

Edward J. Logsdon

14. MOTHER'S MAIDEN NAME

Agnes E. Smizing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

214-07-6497

17. INFORMANT

Mrs. Naomi Logsdon, La Vale Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Pulmonary Hemorrhage

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Pulmonary Tuberculosis

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 day

11 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour e.m.

p.m.

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11 - 15, 19 61, to 5 - 15, 19 61, that (I) (we) last saw the deceased alive on 6 - 1, 19 61 and that death occurred at 11 PM, from the causes and on the date stated above.

22a. SIGNATURE

R. Ballin

M.D.

ATTENDING PHYS.

☒

MED. DIRECTOR

☐

STAFF PHYS.

☐

6-16-61

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

R. BALLIN, M.D.

22d. ADDRESS

62 GREENE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

4/19/61

23c. NAME OF CEMETERY OR CREMATORY

St. Patrick's Cem.

23d. LOCATION (City, town or county)

Cumberland Md

24. FUNERAL DIRECTOR'S SIGNATURE

Louis Stein Inc.

ADDRESS

Cumb. Md.

25a. REC'D BY REGISTRAR

JUN 19 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Fraser

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6308

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G289 6/22/61 iwk

Reg. Dist. No. 06292

| | | | | | |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
West Virginia b. COUNTY
Mineral | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
DOA | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital | | | d. STREET ADDRESS
Rt. #2 Short Gap | | |
| 3. NAME OF DECEASED (Type or print)
Goldie Virginia Long | | | 4. DATE OF DEATH
Month June Day 15 Year 1961 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 26, 1919 | | 9. AGE (in years last birthday)
42 41 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Cumberland, Maryland | |
| 13. FATHER'S NAME
Osa D. Spencer | | | 14. MOTHER'S MAIDEN NAME
Bessie Lewis | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Cletus Long Short Gap, W. Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS
(a), stating the underlying cause last. DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
SUDDEN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Benedict Skitarelic | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type)
Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | June 15, 1961 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/18/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Three Churches Cemetery | |
| 22d. LOCATION (City, town, or county)
Three Churches, W. Va. | | 22e. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Louis Stein Inc. | | ADDRESS
117 Frederick St. Cumb. Md. | | DATE JUN 19 '61 | |

MEDICAL CERTIFICATION

00292

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100

THE STATE
HEALTH DEPT

8

Married

State of Virginia

Married

Married

Dr. J. S. Brown, M.D.

1901

Married

Married

Robert Virginia Lane

Married

Married 1901

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

June 15, 1901

Married

Married

1901

Married

Married

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------------------------|--|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 6309 06293 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
1 1/2 DAYS | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL CUMBERLAND | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SACRED HEART | | | | d. STREET ADDRESS
RT. # 5 | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First MARY Middle Elizabeth Last MCKENZIE | | | | 4. DATE OF DEATH
Month JUNE Day 28 Year 1961 | | | | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-19-? 1896 | | 9. AGE (In years last birthday)
65? yrs. | | IF UNDER 1 YEAR
Months 6 Days 28 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JAMES STOTTLEMYER | | | | 14. MOTHER'S MAIDEN NAME
Molly Clingerman | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
CHART | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) arteriosclerotic heart disease
(c) Gravida | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
one dz | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour e.m. 19 p.m. | | Month, Day, Year | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-3 , 19 60 to 6-28 , 19 61 , that (I) (we) last saw the deceased alive on 6-28 , 19 61 , and that death occurred at 11:02 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
L. Brings | | | | M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
6-29-61 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. L. Brings | | | | 22d. ADDRESS
57 Green Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7/1/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City, town or county) (State)
Cumberland, Maryland | | | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
JUL 3 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hanes | | | |

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(M)

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CERTIFICATE OF DEATH

Reg. Dist. No.

06294

6310

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
02 CUMBERLAND | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
411 AVERITT AVE | | | | d. STREET ADDRESS
1411 AVERITT AVE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
MISS MADELINE RUTH MEERBAUGH | | | | 4. DATE OF DEATH Month Day Year
JUNE 15 1961 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
OCT 3, 1910 | |
| 9. AGE (In years last birthday)
50 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RET. DENTAL ASSISTANT | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
ALTOONA, PENNA. | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
John H. Meerbaugh | | | | 14. MOTHER'S MAIDEN NAME
IRENE KELLY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Miss Hope Kelly 411 AVERITT AVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
170X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Removal of left breast August 58
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8-3-58 to 6-15-61 , that I last saw the deceased alive on 6-10-61 , and that death occurred at 6:20 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 127 Centre St. Cumberland Md
DATE SIGNED 6-17-61
ACTUAL SIGNATURE Wm. X. Williams M.D.
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
JUNE 18, 1961 | | 22c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEMETERY | | 22d. LOCATION (City, town, or county) (State)
CUMBERLAND MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Louis Stein 117 FREDERICK ST. CUMBERLAND MD | | | | 24a. REC'D BY REGISTRAR
DATE JUN 19 1961 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Harris | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6311

CERTIFICATE OF DEATH

06296

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Lonaconing | | c. LENGTH OF STAY IN lb
7 Yrs. | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Lonaconing | | d. STREET ADDRESS
8 Bucks Hill | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
8 Bucks Hill | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Arthur Chester Miller | | | | 4. DATE OF DEATH
June 12 19 61 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 11, 1885 | |
| 9. AGE (in years last birthday)
75 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Yarn Cutter | | 11. BIRTHPLACE (County & State, or foreign country)
W.Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Morgan W. Miller | | | | 14. MOTHER'S MAIDEN NAME
Annie Heavner | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
220-03-7611 | | | |
| 17. INFORMANT
Mrs. Arthur C. Miller | | | | Address
Same as above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Coronary occlusion
DUE TO (b) Arteriosclerotic Cardiovascular disease
DUE TO (c) Pulmonary fibrosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Pulmonary fibrosis
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 9 1961 to June 12 1961 , that (I) (we) last saw the deceased alive on June 9 1961 , and that death occurred at 1 p.m. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
L.R. Miles Jr. | | | | M.D.
L.R. MILES JR., M.D. | | 22b. DATE SIGNED
6.15.61 | |
| 22c. PHYSICIAN'S NAME (Type)
L.R. MILES JR., M.D. | | | | 22d. ADDRESS
LONA CONING MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
June 15, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Bloomington Cem. | | 23d. LOCATION (City, town or county) (State)
Bloomington, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
E. J. Roa | | | | 25a. REC'D BY REGISTRAR
JUN 19 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6312

CERTIFICATE OF DEATH

06297

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--------------------------------------|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg
c. LENGTH OF STAY IN 1b 8 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland Allegany
b. COUNTY Allegany
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 22 Frostburg,
d. STREET ADDRESS 65 Linden Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
Earl Kenneth Miller, Jr. | | 4. DATE OF DEATH
June 12th, 1961 | | 5. SEX Male White | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 24th, 1928 | | 9. AGE (In years last birthday) 32 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer | | 11. BIRTHPLACE (County & State, or foreign country) Frostburg, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Earl Kenneth Miller | | | | 14. MOTHER'S MAIDEN NAME Hazel Ward | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Korean War | | | | 16. SOCIAL SECURITY NO. 212-24-0265 | | | | 17. INFORMANT Mrs. Martha L. Miller, Lonaconing, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute circulatory failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hyperpyrexia due to Cerebral Edema with Coma and Convulsions
(c) Acute Fatty Degeneration of the Liver | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hr.
24 hr.
3 days. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Perforated peptic ulcer; gastric; Surgical closure 6/4/61 | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 4, 1961, to June 12, 1961, that (I) (we) last saw the deceased alive on June 12, 1961, and that death occurred at 8:30 PM from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Alvin J. Walters | | | | 22b. DATE SIGNED
June 16, 1961 | | | | 22c. PHYSICIAN'S NAME (Type) Alvin J. Walters, | | | | 22d. ADDRESS 48 Broadway, Frostburg, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 6-15-61 | | | | 23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park | | | | 23d. LOCATION (City, town or county) Cumberland, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
L. R. Duerst | | | | ADDRESS Frostburg, Md. | | | | 25a. REC'D BY REGISTRAR JUN 19 '61 | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | | | | | |

5120

YES30

6313

CERTIFICATE OF DEATH

Reg. Dist. No. 06298

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|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | | | c. LENGTH OF STAY IN 1b
Lifetime | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4 Standish Street | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MATILDA First G. Middle MILLER Last | | | | 4. DATE OF DEATH
Month 6 Day 17th Year 19 61. | | | |
| 5. SEX F | | 6. COLOR OR RACE M W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-2-1880 | |
| 9. AGE (In years lost birthday) 80 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework(Retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Miners Hospital | | | |
| 13. FATHER'S NAME
William Thomas Gordon | | | | 14. MOTHER'S MAIDEN NAME
Barbara Bennett | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
None | | | |
| 17. INFORMANT
Mrs. J. Bucklew, 4 Standish St., | | | | Address Frostburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-Sclerotic heart disease
420.0 DUE TO (b) 1 year
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 5-1 , 19 61 , to 6-17 , 19 61 , that I last saw the deceased alive on 6-17 , 19 61 , and that death occurred at 4:40 P. M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE H.C. Diehl | | | | DATE SIGNED 6/19/61 | | | |
| PHYSICIAN'S NAME (Type) H.C. Diehl, M.D. | | | | ADDRESS (Street, city or town, state) 39 W. MAIN ST., FROSTBURG, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6-20-61 | | 22c. NAME OF CEMETERY OR CREMATORY
Frostburg Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Frostburg Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Beulah H. Norton | | | | 24a. REC'D BY REGISTRAR
23 East Main, Frostburg, Md. | | | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Kline | | | | DATE
JUN 21 '61 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6314

06299

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD.
c. LENGTH OF STAY IN b
7 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVE. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD.
d. STREET ADDRESS
621 N MECHANIC ST.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
FREDERICK | | First | | Middle | | Last | | 4. DATE OF DEATH
Month
JUNE
Day
19
Year
1961 | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-2-1880 | | 9. AGE (In years last birthday)
80 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Machinist | | | | 10b. KIND OF BUSINESS OR INDUSTRY
W. Md. Rwy. | | | | 11. BIRTHPLACE (County & State, or foreign country)
NEW YORK | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
JAMES A MURRAY | | | | | | 14. MOTHER'S MAIDEN NAME
MARY ANN GAUDELL | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
No, | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
332 X DUE TO
Conditions, if any, which gave rise to immediate cause (b) Generalized Atherosclerosis
(c) —
DUE TO
(e), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
— | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
72 hrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
— | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
— 19 | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not-While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Cumberland, Md. | | 20f. (City or town)
Cumberland, Md. | | 20g. (County)
Allegany | | 20h. (State)
Md. | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/7/51 to 6/19/61 , 19....., that (I) (we) last saw the deceased alive on 6/19/61 , 19....., and that death occurred at 9:40 P.M. the causes and on the date stated above | | | | | | | | | | | | | |
| 22a. SIGNATURE
[Signature]
M.D.
22c. PHYSICIAN'S NAME (Type)
DR. R.J. WILLIAMS | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS
122 CENTRE ST., CUMBERLAND, MD. | | | 22f. DATE SIGNED
6/21/61 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/22/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Davis Cemetery, | | | | 23d. LOCATION (City, town or county) (State)
Davis, W. Va. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George
ADDRESS
Cumberland, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 23 '61 | | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | | |

00283

0012

ALLEGANY

WARRAND

ALLEGANY

(M)

CUMBERLAND, MD.

7 DAYS

CUMBERLAND, MD.

651 W MECHANIC ST.

MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVE.

19 19 01

JUNE

OWBRAY

FREDERICK

60

12-2-1900

X

WHEAT

MALE

U.S.A.

NEW YORK

1012 1012 1012 N. W. WY.

(I)

MARY ANN CARROLL

JAMES A MURRAY

MEMORIAL HOSPITAL, CUMBERLAND, MD.

WHEEL

NO.

155 CENTRE ST., CUMBERLAND, MD.

DR. R. J. WILLIAMS

DAVIS, W. W.

Davis Cemetery,

6/1/01

Arrival

1000 1000 1000

U. Wayne George Cumberland, Md.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-------------------------------|---|--|--|---|--------------------------------------|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 6315 CERTIFICATE OF DEATH 06300 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 11 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. STREET ADDRESS 130 GRAND AVENUE
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) FLORENCE L. NICHOLSON | | | | | | 4. DATE OF DEATH JUNE 16 1961 | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH FEBRUARY 25, 1908 | | 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ODITH M. BROTEMARKLE | | | | | | 14. MOTHER'S MAIDEN NAME FLORENCE L. CORDRY | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | | | 16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | |
| 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anemia, cachexia, dehydration
175.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis - generalized + abdominal
DUE TO (c) Ovarian cancer
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/16 , 19 61 , to 2:05 AM , 19 61 , that (I) (we) last saw the deceased alive on 6/16 , 19 61 , and that death occurred at 2:05 AM , 19 61 , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Thomas F. Lewis | | | | | | 22b. DATE SIGNED 6/19/61 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) DR. THOS. F. LEWIS | | | | | | 22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 6-19-1961 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | | | 23d. LOCATION (City, town or county) (State) Cumberland, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE JUN 22 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

M

ALABAMA

CUMBERLAND

11 DAYS

CUMBERLAND

ALABAMA

MARYLAND

130 GRANT AVENUE

MEMORIAL HOSPITAL
MEMORIAL & MARSH AVE.

WITKOWSKI

J.

FLORENCE

JUNE

FEBRUARY 27, 1908

WHITE

CUMBERLAND, MARYLAND

Own Home

Housewife

FLORENCE J. CORRY

COIT M. BROTHMAN

MEMORIAL HOSPITAL, CUMBERLAND, MD.

NO

I

2:00 PM

James F. Lewis

DR. THOS. F. LEWIS

ALCOHOLIC HOTEL, CUMBERLAND, MD.

Born 1901 6-13-1901 Baltimore, Md.

James F. Lewis, Cumberland, Md.

• IS RESIDENCE ON A FARM?
YES ☐ NO ☒

25b. REGISTRAR'S SIGNATURE
Clifford S. Haines

VR A15 (4)
15M 9/60

00301

11

M

Alfred

Lawrence

Uncle Ernest

Anna

John

Constance

George E. Smith

280-10-2726

Albert Brown, 1000 10th St.

1000 10th St.

April 22, 1910

May 31

John E. Davis

2 Broadway, Brooklyn, N.Y.

Encl.

6-10-10

1st Memorial Park, Brooklyn, N.Y.

Brooklyn, N.Y.

May 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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N

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|---|---|---|---|---|---|--|---|-----------------------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 6317 | | | | | CERTIFICATE OF DEATH | | | | | 06302 | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE MARYLAND ALLEGANY | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND 02 | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SACRED HEART | | | | | d. STREET ADDRESS
424 CUMBERLAND ST. | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
LENA | | | | | First Middle | | Last | | 4. DATE OF DEATH
Month 6 Day 5 Year 1961 | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 22, 1885 | | 9. AGE (In years last birthday)
75? yrs. | | IF UNDER 1 YEAR
Months 7 Days 5 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Switzerland | | | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
Nickolas Rader | | | | | 14. MOTHER'S MAIDEN NAME
Josephine Hockell | | | | | Address | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Chart | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) apoplectic stroke
334X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
30 days
2 years | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
4-4 | | (County)
1260 | | (State)
6-5 |
| 21. I certify that (I) (this hospital) attended the deceased from 4-4 to 6-5 , 19 61 , that (I) (we) last saw the deceased alive on 6-5 , 19 61 , and that death occurred 4:58 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
L Brings | | | | | M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
6-7-61 | | |
| 22c. PHYSICIAN'S NAME (Type)
Lewis Brings, M.D. | | | | | 22d. ADDRESS
57 Greene St. Cumberland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
June 8, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
S.S. Peter & Pauls | | | 23d. LOCATION (City, town or county) (State)
Cumberland Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George, 202 Greene St. Cumberland, Md. | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
JUN 9 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | |

08380

1817

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ATTACHED

ATTACHED

ATTACHED

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ATTACHED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6318
CERTIFICATE OF DEATH
06303

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, Md. | | c. LENGTH OF STAY IN 1b
6 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, Maryland | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Memorial Hospital Memorial & Warwick Ave. | | | | d. STREET ADDRESS
545 Patterson Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Lydia Middle M. Last Ramage | | | | 4. DATE OF DEATH
Month June Day 4 Year 1961 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 6, 1894 | |
| 9. AGE (In years last birthday)
67 yrs. | | 10. IF UNDER 1 YEAR
Months 67 Days 0 Hours 0 Min. 0 | | 11. IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. 0 | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
John D. Pettingall | | | | 14. MOTHER'S MAIDEN NAME
Nancy Pettit | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
215 36 7715 | | 17. INFORMANT
Memorial Hospital, Cumberland, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac decompensation (failure)
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocardial fibrosis; antero-septal infarct
DUE TO
(c) Coronary arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH
36 days
36 days
? | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/27 19 61 to 6/4 19 61 that (I) (we) last saw the deceased alive on 6/4 19 61 , and that death occurred at M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Samuel M. Jacobson for S. G. Weisman, M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE
6/14/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Samuel M. Jacobson for S. G. Weisman, M.D. | | | | 22d. ADDRESS
50 Pershing St. Cumberland, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
June 7, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Philos Cemetery | | 23d. LOCATION (City, town, or county) (State)
Westernport, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Byron Kight | | | | ADDRESS
Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE JUN 19 '61 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles S. Evans | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 6319 CERTIFICATE OF DEATH 06304 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b
<u>41 da., 20 min.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland, Maryland.</u> X | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Sacred Heart Hospital</u> | | | | | | d. STREET ADDRESS
<u>Rt. #4, Christie Road., Cumb.</u> | | | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>John</u> Middle <u>Louis</u> Last <u>Rice</u> | | | | | | 4. DATE OF DEATH
Month <u>June</u> , Day <u>22</u> , Year <u>1961</u> | | | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>10-3-1883</u> | | 9. AGE (In years last birthday)
<u>77</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired employee</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Greenhouse</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Charles Rice</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Caroline Newell</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>Unknown</u> | | | | 16. SOCIAL SECURITY NO.
<u>217-10-1950</u> | | 17. INFORMANT
<u>Chart</u> | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastasis to liver, peritoneum and pleura</u>
151X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u>
(c) <u> </u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | | | | |
| 20c. TIME OF INJURY
Hour <u>a.m.</u> <u>19</u> p.m. | | Month, Day, Year | | 20d. INJURY OCCURRED
While <u>Not White</u> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town)
<u> </u> | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12 Mar, 1961</u> , to <u>6/22/61</u> , that (I) (we) last saw the deceased alive on <u>6/21</u> , 19 <u>61</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>S.A.G. Weisman</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>S.A.G. Weisman</u> | | | | | | 22d. ADDRESS
<u>59 Greene St., Cumberland, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>June 25, 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt Herman Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State)
<u>Cumberland Maryland</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Ruth E. Silcox</u> | | | | | | ADDRESS
<u>Cumberland Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUN 27 '61</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | |

00304

7313

(M)

(1)

Examination of specimen with reference to
liver, omentum and spleen

217-10-1050

Examination of specimen

Examination of specimen

Examination of specimen

217-10-1050

Examination of specimen

Examination of specimen

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6320

06305

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND ALLEGANY
b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 2 DAYS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART | | | | e. STREET ADDRESS 859 CAMDEN AVENUE | | | |
| 3. NAME OF DECEASED
(Type or print) WILLIAM CARL RICHARDS | | | | 4. DATE OF DEATH JUNE 5, 19 61 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-9-87 | |
| 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR | | 11. IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME T. DAVIS RICHARDS | | | | 14. MOTHER'S MAIDEN NAME SARAE CARL RICHARDS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. CHART | | | |
| 17. INFORMANT CHART | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Disease
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) 420.1
(c) 420.1
(e), stating the underlying cause last. DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 mos |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-10-60 to 6-5-61 , that (I) (we) last saw the deceased alive on 6-4-61 , and that death occurred at 2:30 , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE R. W. Ballin | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 6-5-61 | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. R.W. Ballin, M.D. | | | | 22d. ADDRESS 62 Green Street Cumberland, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 6/7/61 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem. | | 23d. LOCATION (City, town or county) (State) Cumberland Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. | | | | ADDRESS Cumb. Md | | 25a. REC'D BY REGISTRAR JUN 8 '61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kram | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 6321 | | | | | | | | | | | |
| 06306 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 64 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRING GAP
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) CHARLIE | | First L. intle | | Middle RILEY | | Last | | 4. DATE OF DEATH
Month JUNE
Day 13
Year 19 61 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH SEPTEMBER 3, 1898 | | 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY B&O RR | | 11. BIRTHPLACE (County & State, or foreign country) KANSAS, Iola | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HUGH RILEY | | | | 14. MOTHER'S MAIDEN NAME MARY SMULTZ | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. WW 1 | | 17. INFORMANT MEMORIAL HOSPITAL | | Address CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: Left ventricular failure
IMMEDIATE CAUSE (a) 420.1
DUE TO (b) Cerebral embolus, lt. with paralysis, rt. side
DUE TO (c) Hypertention; Coronary arteriosclerosis; myocardial fibrosis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
2 months
4 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour e.m.
p.m. 19 | | Month, Day, Year | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/10 , 19 61 to 6/13 , 19 61 ; that (I) (we) last saw the deceased alive on 6/12 , 19 61 , and that death occurred 2:20 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22e. SIGNATURE Samuel M. Jacobson for Dr. G. Weisman
M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) SAMUEL M. JACOBSON
G. G. Weisman, M. D. | | | | | | 22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.
59 Greene St. | | 22b. DATE SIGNED 6/14/61 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 6/15/61 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Meth. Cem. | | 23d. LOCATION (City, town or county) (State) Near Cumberland, Maryland | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 16 '61 | | 25b. REGISTRAR'S SIGNATURE
William S. Kneass | | | |

00308

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ALLEGANY

MARYLAND

ALLEGANY

SPRING GAP

64 DAYS

CUMBERLAND

MEMORIAL HOSPITAL
MEMORIAL & WARREN AVES.,

RILEY

L. S. S.

CHARIE

WHITE

SEPTEMBER 3, 1908

U.S.A.

KANSAS, 1908

MARY SMUTZ

HUGH RILEY

CUMBERLAND, MD.

MEMORIAL HOSPITAL

1911

SAUEL M. JACOBSON

50 PERSHING ST., CUMBERLAND, MD.

John J. Baker, Cumberland, Maryland

W. J. Baker, Cumberland, Maryland

1
M
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|--|----------------------------------|--|---|--|--|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 6322 | | | | | 06307 | | | | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | | | | | | |
| a. COUNTY
ALLEGANY | | | | | a. STATE
MARYLAND | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | | b. COUNTY
ALLEGANY | | | | | | | | | |
| c. LENGTH OF STAY IN 1b
90 DAYS | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | | | | d. STREET ADDRESS
137 *111* PENNSYLVANIA AVENUE | | | | | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First | | Middle | | Last | | 4. DATE OF DEATH | | | | | |
| | | | EDITH | | C. | | RYAN | | Month
JUNE | | | | | |
| 5. SEX
FEMALE | | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
OCT. 31, 1903 | | 9. AGE (In years last birthday)
57 yrs. | | | | | |
| | | | | | | | | | IF UNDER 1 YEAR
Months Days Hours Min. | | | | | |
| | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BOOKKEEPER | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
CHANEY TRANSPORTATION CO. | | | | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | | | | | | |
| 13. FATHER'S NAME
WALTER WOLVERTON | | | | | 14. MOTHER'S MAIDEN NAME
BERTIE LONG | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
214-05-8828 | | | | | 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND | | | | |
| | | | | | Address | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatous primary site Cervix
171X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO
(c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 171X | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 yr - | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.
19 | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Cumberland, Md. | | | | |
| 20f. (City or town)
Cumberland, Md. | | | | | 20g. (County)
Allegany | | | | | 20h. (State)
Md. | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/7/60 to 6/2/61 , 19....., that (I) (we) last saw the deceased alive on 6/1/61 , 19....., and that death occurred at 4:45 A.M. , from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
DR. R. J. WILLIAMS | | | | | 22b. DATE SIGNED
6/2/61 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS
122 S. CENTRE STREET, CUMBERLAND, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE THEREOF
June 4, 1961 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Zion Memorial Park | | | | |
| 23d. LOCATION (City, town or county)
Cumberland Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ruth E. Silcox | | | | | ADDRESS
Cumberland Maryland | | | | | 25a. REC'D BY REGISTRAR
JUN 5 '61 | | | | |
| | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | | |



ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

FEMALE WHITE

BOOKKEEPER

WALTER WOLFE

90 DAYS

CUMBERLAND

317 PENNSYLVANIA AVENUE

RYAN

OCT. 31, 1908

27

JUNE

ALLEGANY

MARYLAND

00303

U.S.A.

MARYLAND

CRANEY TRANSPORTATION CO.

BERTIE LOWE

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

201-5-5833

133 S. CENTRE STREET, CUMBERLAND, MD.

DR. R. J. WILLIAMS

Cumbersland Maryland

Cumbersland Maryland

Cumbersland Maryland

Cumbersland Maryland

Cumbersland Maryland

DATE JUN 19 '61

VR A15 (4)
15M 9/60

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

2 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

630 GREENE STREET

WAGON

T. SCHRAMM

LINE

FEMALE WHITE

7-15-1903

DR. SAVAGE, MARYLAND

HOSPITAL

HARRY A. RITZER

THEODORE A. RITZER

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

Handwritten notes:
Theodore A. Ritzer - Harry A. Ritzer
with left corner
2 days

133 VIRGINIA AVENUE, CUMBERLAND, MD.

DR. G. D. HILKEMIGHT

DR. G. D. HILKEMIGHT

DR. G. D. HILKEMIGHT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06309

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cresaptown | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital--DOA | | | | d. STREET ADDRESS
1 | | | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle SMITH Last SMITH | | | | 4. DATE OF DEATH
Month June Day 13 Year 19 61 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 29 1880 | |
| 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Telegraph Operator Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY
B & O | | 11. BIRTHPLACE (State or foreign country)
Boston Md | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Smith | | | | 14. MOTHER'S MAIDEN NAME
Margaret Shaw | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Address
Mrs. Louisa Smith Cresaptown Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis
DUE TO (c) Diabetes Mellitus
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus
INTERVAL BETWEEN ONSET AND DEATH
Sudden
----- | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 13, 1961 | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
6/16/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Pl. | | 22d. LOCATION (City, town, or county) (State)
Cumb. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Louis Stein Inc. Cumb. Md | | | | 24a. REC'D BY REGISTRAR
JUN 15 '61 | | 24b. REGISTRAR'S SIGNATURE
Calvin S. Kraus | |

06803

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
<u>John Doe</u> | | 2. SEX
<u>Male</u> | |
| 3. AGE
<u>45</u> | | 4. RACE
<u>White</u> | |
| 5. DATE OF DEATH
<u>Jan 15, 1968</u> | | 6. TIME OF DEATH
<u>10:00 AM</u> | |
| 7. PLACE OF DEATH
<u>Home</u> | | 8. STREET ADDRESS
<u>123 Main St</u> | |
| 9. CITY
<u>Baltimore</u> | | 10. STATE
<u>Md</u> | |
| 11. ZIP CODE
<u>21201</u> | | 12. COUNTY
<u>Baltimore</u> | |
| 13. OCCUPATION
<u>Teacher</u> | | | |
| 14. MARITAL STATUS
<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | |
| 15. NAME OF SPOUSE
<u>Jane Doe</u> | | | |
| 16. NAME OF NEXT OF KIN
<u>John Doe</u> | | | |
| 17. NAME OF PHYSICIAN
<u>Dr. Smith</u> | | | |
| 18. NAME OF HOSPITAL
<u>None</u> | | | |
| 19. CAUSE OF DEATH
<u>Heart Disease</u> | | | |
| 20. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined | | | |
| 21. SIGNATURE OF MEDICAL EXAMINER
<u>[Signature]</u> | | | |
| 22. SIGNATURE OF WITNESS
<u>[Signature]</u> | | | |
| 23. SIGNATURE OF DECEASED
<u>[Signature]</u> | | | |

(M)

RECEIVED JAN 16 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|----------------------------------|---|---|--|--|--|---|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 06310 | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND
c. LENGTH OF STAY IN 1b
5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
MIDLAND
d. STREET ADDRESS
1
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
MARION D. STEIDING | | | | | | 4. DATE OF DEATH
Month JUNE Day 20 Year 1961 | | | | | | | | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
FEBRUARY 1, 1888 | | 9. AGE (In years last birthday)
73 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
JOHN PEEBLES | | | | | | 14. MOTHER'S MAIDEN NAME
RACHEL M. MORGAN | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | | | | 16. SOCIAL SECURITY NO.
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | | | | | | | | | | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | | | | | Address | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331X DUE TO (b) Arterio-sclerotic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) vascular disease, advanced
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
INTERVAL BETWEEN ONSET AND DEATH
5 days | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
6-15-61 to 6-20-61 | | 20g. (County)
1:18 AM | | 20h. (State)
that (I) saw the deceased alive on 6-19-61, and that death occurred at 1:18 AM the causes and on the date stated above. | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-15-61 to 6-20-61 that (I) saw the deceased alive on 6-19-61 , and that death occurred at 1:18 AM the causes and on the date stated above. | | | | | | 22a. SIGNATURE
W. F. Williams
22c. PHYSICIAN'S NAME (Type)
DR. W. F. WILLIAMS | | | | | | 22b. DATE SIGNED
6-20-61
22d. ADDRESS
122 S. CENTRE STREET, CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
6/22/1961 | | | 23c. NAME OF CEMETERY OR CREMATORY
Elk Garden Cemetery | | | 23d. LOCATION (City, town or county)
Elk Garden, West Virginia | | | 23e. (State)
West Virginia | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | | | | | 25. REC'D BY REGISTRAR
DATE JUN 23 '61 | | | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thoms | | | | | |

00310

(M)

ALLEGANY

WARRAND

ALLEGANY

CLARKLAND

2 DAYS

MIDLAND

RECOVERING HOSPITAL
RECOVERING & IMPROVING AVE.

WARRAND

STEIDING

JUNE

FEBRUARY 1, 1902

FEMALE

X

WARRAND

WARRAND

U.S.A.

JOHN REYNOLDS

RACHEL MORGAN

MEMORIAL HOSPITAL, CLARKLAND, WARRAND

TO

(I)

Handwritten notes:
Clerical Department
State of West Virginia
Voluntary Hospital

6-15-01

6-14-01

DR. W. F. WILLIAMS

122 S. CENTRAL STREET, CLARKLAND, W.

George Richmond, Donnanville, W.

June 14, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

6326

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06311

| | | | | | | | |
|---|----------------------------------|--|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | c. LENGTH OF STAY IN 1b
50 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
21 Frostburg | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
34 McCulloh St. | | | | d. STREET ADDRESS
1 34 McCulloh St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Clarence Middle Stevens Last Stevens | | | | 4. DATE OF DEATH
Month June Day 5th Year 1961 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 27th, 1888 | | 9. AGE (In years last birthday)
72 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY
Brethern Church | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Theophilus Stevens | | | | 14. MOTHER'S MAIDEN NAME
Amanda Middleton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
216-10-4513 | | 17. INFORMANT
Box 135 Address
Arthur Stevens, Rt. 3, Frostburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 022X DUE TO Ruptured Aortic Aneurysm
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Insufficiency DUE TO
(c) Sudden | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 20, 1961 , to June 5, 1961 , that (I) (we) last saw the deceased alive on June 1, 1961 , and that death occurred on June 5, 1961 , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
W. O. McLane | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
May 6, 1961 | |
| 22c. PHYSICIAN'S NAME (Type)
W. O. McLane, | | | | 22d. ADDRESS
167 E. Main St., Frostburg, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6-8-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Eckhart Cemetery | | 23d. LOCATION (City, town, or county) (State)
Eckhart, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
L. P. Duvost | | | | 25a. REC'D BY REGISTRAR
DATE JUN 9 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

06311

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6327

06312

Item 8 Film 6288 6/20/61 mb

| | | | |
|--|--|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,
c. LENGTH OF STAY IN 1b Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 207 Grand Ave. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland
f. COUNTY Allegany
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland, Md.
d. STREET ADDRESS 207 Grand Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Katie Keller Stevenson | | 4. DATE OF DEATH June 12, 19 61 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 25, 1889 |
| 9. AGE (In years last birthday) 71 yrs. | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Owen Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME J. Nelson Barger | | 14. MOTHER'S MAIDEN NAME Margaret Cook | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT James Stevenson | | Address 207 Grand Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
443X DUE TO Cerebral hemorrhage
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease
(c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 10 hrs 2 1/2 hrs 7 1/2 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 17 June 1961 to 18 June 1961 , that (I) (we) last saw the deceased alive on 17 June 1961 , and that death occurred 6:40 PM , from the causes and on the date stated above. | | | |
| 22. SIGNATURE David T. Rees | | 22b. DATE SIGNED 13 June 61 | |
| 22c. PHYSICIAN'S NAME (Type) David T. Rees | | 22d. ADDRESS 702 Montgomery Ave Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 6-14-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | | 23d. LOCATION (City, town or county) (State) Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli | | 24b. ADDRESS Cumberland, Md. | |
| 25a. REC'D BY REGISTRAR JUN 14 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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807 Grand Ave.

807 Grand Ave.

Stevenson

Keller

Katie

June 18

61

Dec. 25, 1960 VI

Dec. 25, 1960 VI

Cumberland, Md.

Owen Home

Home

Walter Cook

J. Nelson Carter

James Stevenson 807 Grand Ave

Home

no

(I)

Cumberland, Md.

Home Hill Co.

6-1-61

Burial

James F. Scott

James F. Scott

James F. Scott

David T. Nees

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|---|---|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 6328 | | | | | | | | | | | |
| 06313 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND
c. LENGTH OF STAY IN 1b
42 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
PENNSYLVANIA
b. COUNTY
CAMBERIA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
JOHNSTOWN
d. STREET ADDRESS
332 KENNARD STREET
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
ANDREW JOHN SVEC JR. | | | | | | 4. DATE OF DEATH
Month Day Year
JUNE 7 1961 | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
NOVEMBER 28, 1906 | | 9. AGE (In years last birthday)
54 | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self Employed | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Plumbing & Heating | | | | 11. BIRTHPLACE (County & State, or foreign country)
JOHNSTOWN, PA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ANDREW JOHN SVEC, SR. | | | | | | 14. MOTHER'S MAIDEN NAME
ANNA KMEC | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give year or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic vascular disease
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Emphysema
(c) Arteriosclerosis advanced aorta and coronary vessels
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Fibroid Phthisis, inactive
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-6-61 to 6-7-61 that (I) (we) saw the deceased alive on 6-6-61 , and that death occurred 8:35 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
W.F. Williams M.D. | | | | | | 22b. DATE SIGNED
6/7/61 | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
W.F. WILLIAMS | | | | | | 22d. ADDRESS
122 SOUTH CENTRE ST., CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE THEREOF
6-10-61 | | | 23c. NAME OF CEMETERY OR CREMATORY
GRANDVIEW CEMETERY | | | 23d. LOCATION (City, town or county) (State)
JOHNSTOWN, PA | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Afer, Cumberland, Md | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 13 '61 | | | 25b. REGISTRAR'S SIGNATURE
Robert L. Kneass | | |

VR A15 (4)
15M 9/60

(M)

00313

WILLIAM

PENNSYLVANIA

CAMERA

CUMBERLAND

15 DAYS

JOHNSTOWN

HOSPITAL & MARSH AVE.,
HOSPITAL

335 KENNEDY STREET

ANDREW

JOHN

SWC. JR.

JUNE

61

WHITE

MALE

NOVEMBER 28, 1960

Self Employed Plumbing & Heating
JOHNSTOWN, PA.
U.S.A.

ANDREW JOHN SWC. JR.

ANNA KEE

No

(I)

HOSPITAL, QUEBEC, CANADA

Letter to the hospital

Complaint

Letter to the hospital

Letter to the hospital

6:32 AM

W. WILLIAMS

GRANDVIEW CEMETERY

JOHNSTOWN

PA

6-10-61

SERIAL

John & Anna Williams

ON 11-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 6329 | | | | | | 06314 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
2 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | d. STREET ADDRESS
209 PENNSYLVANIA AVE. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL
WARWICK & MEMORIAL AVENUES | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First JOHN Middle W. Last TEDERICK | | | | | | 4. DATE OF DEATH
Month JUNE Day 9 Year 19 61 | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JANUARY 4, 1878 | | 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (County & State, or foreign country)
WEST VIRGINIA | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 13. FATHER'S NAME
MICHAEL TEDERICK | | | | | | 14. MOTHER'S MAIDEN NAME
ANN KERNS | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO.
(If yes give number and date of service) | | 17. INFORMANT
Address
MEMORIAL HOSPITAL - CUMBERLAND, MD. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardia
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Coronary Thrombosis
(c) Acute
(e), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
no | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour e.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 7, 1961 to June 9, 1961 , that (I) (we) last saw the deceased alive on June 9, 1961 , and that death occurred at 7:40 AM from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Clay E. Durrett | | | | | | M.D.
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
DR. CLAY E. DURRETT | | | | | | 22d. ADDRESS
236 VIRGINIA AVE., CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6-12-1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenway Cemetery | | 23d. LOCATION (City, town or county) (State)
Berkley Springs, W. Va. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 14 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. House | | | |

(M)

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

2 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

MARWICK & MEMORIAL AVENUES

505 PENNSYLVANIA AVE.

JOHN

W.

THEODORICK

JUNE

JANUARY 11, 1878

WHITE

MALE

Retired Engineer

Balltown

WEST VIRGINIA

MICHAEL THEODORICK

AND KENNETH

MEMORIAL HOSPITAL - CUMBERLAND, MD.

no

(I)

DR. CLAY E. DUBOIS

255 VIRGINIA AVE., CUMBERLAND, MD.

Burial

8-1-1961

Greenway Cemetery

Berkeley Springs, W. Va.

James E. Campbell, Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| <div>1</div> <div>6330</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>06315</div> | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY, W.VA
c. LENGTH OF STAY IN 1b 3HRS. 48 MIN
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVE. | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE W.VA.
b. COUNTY MINERAL ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY, W.VA
d. STREET ADDRESS MILLER ROAD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) BABY BOY | | | 4. DATE OF DEATH
Month JUNE Day 7 Year 1961 | | | 5. SEX
MALE | | | 6. COLOR OR RACE
WHITE | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
JUNE 7, 1961 | | | 9. AGE (In years last birthday) 3 yrs. 48 hrs. <div>IF UNDER 1 YEAR: Months 3 Days 48</div> <div>IF UNDER 24 HRS.: Hrs 48</div> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | |
| 13. FATHER'S NAME
RONALD F. TWIGG | | | | | | 14. MOTHER'S MAIDEN NAME
BETTY JO SCHOONOVER | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 776 Prematurity DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Hour 19 e.m. p.m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 7, 1961 to June 7, 1961 , that (I) (we) last saw the deceased alive on June 7, 1961 , and that death occurred at 10:00AM on the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
DR. ROYCE HODGES | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS
122 S CENTRE ST., CUMBERLAND, MD | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | | 23b. DATE THEREOF
June 8, 1961 | | | 23c. NAME OF CEMETERY OR CREMATORY
Memorial Hospital | | | 23d. LOCATION (City, town or county) (State)
Cumberland, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Memorial Hospital, Cumberland, MD | | | | | | 25a. REC'D BY REGISTRAR
JUN 16 '61 | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | | | | | | | | | |

2060191XV0

00318

00320

MINERAL

N.A.A.

ALLEGANY

RIDGELEY, W. VA.

CHRS. 18 MIN

RIDGELEY, W. VA.

1 MILLER ROAD

MEMORIAL HOSPITAL
HARRIS & HARRIS AVE.

1 18

JUNE

THIGG

BABY BOY

JUNE 7, 1961

WHITE

1012

BETTY JO SCHOOVER

RONALD F. THIGG

MEMORIAL HOSPITAL, CUMBERLAND, MD

10:00AM

152 S CENTRE ST., CUMBERLAND, MD

DR. ROYCE HODGES

(M)

(2)

(1)

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6331
CERTIFICATE OF DEATH
06316

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
11/20/58 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Allegany County Infirmary | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Minnie Christine Valentine | | 4. DATE OF DEATH
Month Day Year
June 15, 19 61 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/23/1869 |
| 9. AGE (In years last birthday)
92 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
James Asias Wilson | | 14. MOTHER'S MAIDEN NAME
Annie Troxell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No. | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
P.O.Box 599 | | Address Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration
DUE TO 592X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Arteriosclerosis
DUE TO
(c) Chronic Hepatitis | | INTERVAL BETWEEN ONSET AND DEATH
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Senile Degeneration | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/20/58 19 to 6/15/61 19, that (I) (we) last saw the deceased alive on 6/14/51 19, and that death occurred at 2:30 A.M. M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. James E. McLean M.D. | | 22b. DATE SIGNED
6/15/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. James E. McLean | | 22d. ADDRESS
49 Greene St., Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/17/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George | | 25a. REC'D BY REGISTRAR
DATE JUN 19 '61 | |
| ADDRESS
Cumberland, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles L. Evans | |

00316

UNITED STATES OF AMERICA

1951

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

X

Allegany

Allegany County Jail

01

15

June

Allegany

Allegany

Allegany

01

Allegany

X

Allegany

Allegany

U. S. A.

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany County Jail

Allegany

01/25/51

01/25/51

01/25/51

01/25/51

X

Allegany County Jail

Allegany County Jail

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Allegany

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6332

06317

| | | | | | | | |
|--|----------------------------------|---|---------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVE. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
d. STREET ADDRESS 203 VIRGINIA AVE.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
GEORGE C. arl WACHTER | | 4. DATE OF DEATH
Month JUNE Day 22 Year 19 61 | | | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-29-1904 | 9. AGE (In years last birthday)
56 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SELF EMPLOYED | | 10b. KIND OF BUSINESS OR INDUSTRY
RETAIL MERCHANT | | 11. BIRTHPLACE (County & State, or foreign country)
CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
REVERDY WACHTER | | | | 14. MOTHER'S MAIDEN NAME
ELIZABETH HOGGHEWORTH Hausorath | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
214-32-2872 | | 17. INFORMANT
Address MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Nephritis & Anemia
592X DUE TO
Conditions, if any, which gave rise to immediate cause (b) _____
(c) _____
cause test. DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH 72 hrs | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md. | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/2/61 , 19____, to 6/22/61 , 19____, that (I) (we) last saw the deceased alive on 6/22/61 , 19____, and that death occurred at 6:35 P.M. on the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
DR. R.J. WILLIAMS | | | | 22b. DATE SIGNED
6/23/61 | | 22c. PHYSICIAN'S NAME (Type)
DR. R.J. WILLIAMS | |
| 22d. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/25/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 23d. LOCATION (City, town or county) (State)
Cumberland, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE JUN 29 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

00317

0032



WILLIAM

HARRARD

ALLEGANY

CUMBERLAND, MD.

3 DAYS

CUMBERLAND, MD.

RENTAL (HOTEL)

RENTAL & MAINTENANCE

507 VIRGINIA AVE.

GEORGE

WANTED

JUNE

22

61

11-10-1904

WHITE

MALE

SELF EMPLOYED

RETAIL MERCHANT

IN ENGLAND, EN

U.S.A.

REVERLY WANTED

ELIZABETH (WIDOWED)

GENERAL HOSPITAL, CUMBERLAND, MD.

No



132 S. CENTRE ST., CUMBERLAND, MD.

DR. R. J. WILLIAMS

CUMBERLAND, ENGLAND

BRUNNEN (FARMING) FIRM

BRUNNEN (FARMING) FIRM

JOHN J. LANE, CUMBERLAND, ENGLAND

JUN 24 1904

6333
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 06318

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND | |
| c. LENGTH OF STAY IN 1b LIFE | | d. STREET ADDRESS BEDFORD ROAD ROUTE 3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BEDFORD ROAD ROUTE 3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ETTA E. WHITE | | 4. DATE OF DEATH JUNE 16, 19 61 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 18, 1887 |
| 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY GROCERY | |
| 11. BIRTHPLACE (State or foreign country) PENNA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WM. H. TWIGG | | 14. MOTHER'S MAIDEN NAME ELIZA LEASURE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 214 42 0046 | |
| 17. INFORMANT ALBURTUS WHITE, ROUTE 3, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Immediate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/3/52 19 to 6/16/61 19, that (I) (we) last saw the deceased alive on 6/14/61 19, and that death occurred at 9:58 from the causes and on the date stated above. | | | |
| 22a. SIGNATURE [Signature] | | 22b. DATE 6/18/61 | |
| 22c. PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS, M. D. | | 22d. ADDRESS CUMBERLAND ALLEGANY MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF JUNE 19, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY CENTERARY CEMETERY | | 23d. LOCATION (City, town, or county) (State) ROUTE 3, CUMBERLAND, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT | | 24a. REC'D BY REGISTRAR JUN 21 '61 | |
| ADDRESS CUMBERLAND, MD. | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

06312

CERTIFICATE OF DEATH

(M)

(T)

RECEIVED
U.S. DEPT. OF HEALTH
DIVISION OF VITAL STATISTICS
WASHINGTON, D.C.

NOV 1964

MADE IN U.S.A.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6334 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06319

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Flintstone | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | | | d. STREET ADDRESS
/ | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Nora Middle Estella Last Wigfield | | | | 4. DATE OF DEATH
Month June Day 3 Year 19 61 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 10 1878 | |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months 83 Days 83 | | IF UNDER 24 HRS.
Hours 83 Min. 83 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (State or foreign country)
Penna | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Simon P. Oster | | | | 14. MOTHER'S MAIDEN NAME
Martha Mauck | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
Leslie M. Wigfield Flintstone, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease
DUE TO (c) Fracture of Left Hip
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Left Hip
INTERVAL BETWEEN ONSET AND DEATH
Years
Years | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Tripped and fell at home in the kitchen | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
3:00 P. m. May 29 1961 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Flintstone, Alleg. Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 3, 1961 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 6, 1961 | | 22c. NAME OF CEMETERY OR CREMATORY
I.O.O.F. Cemetery | | 22d. LOCATION (City, town, or county) (State)
Flintstone Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ruth E. Silcox
ADDRESS
Cumberland Maryland | | | | 24a. REC'D BY REGISTRAR
DATE JUN 5 '61 | | 24b. REGISTRAR'S SIGNATURE
William S. Thomas | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6335

06320

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
c. LENGTH OF STAY IN 1b 4 weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
d. STREET ADDRESS R.D. #2 (Consolidation)
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) ISABEL D. WINNER | | 4. DATE OF DEATH
June 13 1961. | | 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7-6-1918 | | 9. AGE (In years last birthday)
42 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 | | 11. IF UNDER 24 HRS.
Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | 11. BIRTHPLACE (County & State, or foreign country)
Deer Park, Md. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Herman Landis | | | | | | 14. MOTHER'S MAIDEN NAME
Katherine Madigan | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | | | 16. SOCIAL SECURITY NO.
None | | | | | | 17. INFORMANT
Manuel Winner, R.D. #2, Frostburg, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 153.9 DUE TO Coronary occlusion 24 hrs
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Carcinoma of bowels years
(c) | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 1961, to 6/14/61, that (I) (we) last saw the deceased alive on 6/14/61, and that death occurred at 11 A.M., from the causes and on the date stated above. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
John B. Davis, M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS
Frostburg, Md. | | | | | | 22b. DATE SIGNED
6/14/61 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
6/16/61 | | | | 23c. NAME OF CEMETERY OR CREMATORY
St. Michaels Cemetery | | | | 23d. LOCATION (City, town or county) Frostburg (State) Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Paul H. Montague | | | | | | 25a. REC'D BY REGISTRAR
JUN 19 61 | | | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | | | |
| 3 E. Main, Frostburg, Md. | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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(M)

(I)

ALLEGANY
 CUMBERLAND
 10 Mrs. ZOMM.
 CUMBERLAND
 50 GREEN ST.
 X

WISCONSIN
 10-1-1914
 WHITE

ALBERT RUSSE WISOMAN
 LAURA (LAE) PRICE
 U. S. A.

11-1-1914
 11-1-1914

1:30 P.M.
 ALLEGANY HOTEL, CUMBERLAND, MD.
 DR. GEORGE M. STONE

11/1/14
 11/1/14
 11/1/14

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6337

CERTIFICATE OF DEATH

06321

| | | | | | | | | | | | | | | | |
|--|------------------|--|--|---|--|---|--|--|--|---|------------------|--------|------|-------|------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 18 DAYS 8 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART Hosp. | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE MARYLAND ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. STREET ADDRESS CASH VALLEY ROAD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) FRANCIS O. WISENBERG | | | | 4. DATE OF DEATH
Month 6 Day 11 Year 1961 | | | | | | | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-29-09 | | 9. AGE (In years last birthday) 52 yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| Months | Days | | | | | | | | | | | | | | |
| Hours | Min. | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN-B&ORR Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | | | | | |
| 13. FATHER'S NAME
James J. Wisenberg | | | | 14. MOTHER'S MAIDEN NAME
CLARA JANE TRUE (D) | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN | | | | 16. SOCIAL SECURITY NO.
2 12-18-177 | | 17. INFORMANT
CHART | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO 420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AS4D
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Branchial Aneurysm | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/14/60 , 19 60 , to 6/11 , 19 61 , that (I) (we) last saw the deceased alive on 6/11 , 19 61 , and that death occurred at 5:18 PM from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
William P. James M.D. | | | | | | | | 22b. DATE SIGNED
6/11/61 | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
WILLIAM P. JAMES, M.D. | | | | | | | | 22d. ADDRESS
441 N. CENTRE ST. CUMBERLAND, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF
6/13/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Cem. | | 23d. LOCATION (City, town or county) Cumberland MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Louis Stein Inc | | | | | | | | 25a. REC'D BY REGISTRAR
JUN 15 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06323

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
5yrs;1mo;25das. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
12 Cumberland, M | | d. STREET ADDRESS
126 Beall Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sylvan Retreat | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Edward Middle Benjamin Last Witt | | 4. DATE OF DEATH
Month 6 Day 21 Year 19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 14, 1885 |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Railroad | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Witt | | 14. MOTHER'S MAIDEN NAME
Alcindia Norris | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Sylvan Retreat Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420 Arteriosclerotic Heart Disease
592X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 450 General Arteriosclerosis
DUE TO
(c) 592 Chronic Nephritis | | INTERVAL BETWEEN ONSET AND DEATH
?
?
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome & Alcoholism. | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Apr 26, 1955 to June 22, 1961 , that I last saw the deceased alive on June 21, 1961 , and that death occurred at 6:20 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
James E. McLean M.D. | | ADDRESS (Street, city or town, state)
49 Greene St | |
| PHYSICIAN'S NAME (Type)
James E. McLean, M.D. | | DATE SIGNED
6/22/61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/24/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt. Herman Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR
DATE JUN 26 '61 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

CERTIFICATE OF DEATH

00323

14

| | | | | | | | | | |
|------------------------|--|------------------------|--|--------------------------|--|----------------------|--|----------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | Jan 1, 1900 | | Baltimore, Md. | |
| Cause of Death | | Immediate Cause | | Underlying Cause | | Manner of Death | | Place of Death | |
| Heart Disease | | Myocardial Infarction | | Coronary Atherosclerosis | | Natural | | Home | |
| Occupation | | Education | | Marital Status | | Previous Illnesses | | Date of Death | |
| Teacher | | High School | | Married | | Hypertension | | Jan 15, 1945 | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | | Signature of Witness | | Signature of Coroner | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6339

CERTIFICATE OF DEATH

Reg. Dist. No. 06324

| | | | |
|--|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b Yrs. 9mo. 26das. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First John Middle F. Last Wolf | | 4. DATE OF DEATH Month June Day 12 Year 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/1/81 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR Months 02 Days 02 Hours 02 Min. | IF UNDER 24 HRS. 02 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John F. Wolf | | 14. MOTHER'S MAIDEN NAME Amanda E. Worles | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Sylvan Retreat Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 592x 420 Arteriosclerosis Heart Disease
DUE TO (b) 450 General Arteriosclerosis
DUE TO (c) 592 Chronic Nephritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 304 Severe psychosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 18, 1955 to June 12, 1961 , that I last saw the deceased alive on June 11th, 1961 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James E. McLean M.D. | | ADDRESS (Street, city or town, state) 49 Greene St DATE SIGNED 6/13/61 | |
| PHYSICIAN'S NAME (Type) James E. McLean, M.D. | | 49 Greene Street, Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/15/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY Allegany Co. Cemetery | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR JUN 16 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6340

06325

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|----------------------------------|--|---|--|--|--|---|--|---|--|---|--|-------------------------|--|------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
CUMBERLAND
c. LENGTH OF STAY IN 1b
71 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
MEMORIAL HOSPITAL,
MEMORIAL & WARWICK AVES., | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG
d. STREET ADDRESS
E. MAIN STREET
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
NELLE M ZELLER | | 4. DATE OF DEATH
Month
JUNE
Day
13
Year
61 | | 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JULY 13, 1886 | | 9. AGE (In years birthday)
74 | | IF UNDER 1 YEAR
Months
Days
Hours
Min. | | IF UNDER 24 HRS.
Hours
Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | 11. BIRTHPLACE (County & State, or foreign country)
GRANTSVILLE, MD. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME
NOAH BROADWATER | | | | 14. MOTHER'S MAIDEN NAME
EMMA CHAPMAN | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No None None | | | | 16. SOCIAL SECURITY NO.
None | | | | 17. INFORMANT
MEMORIAL HOSPITAL,
Address
CUMBERLAND, MD. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetic coma
260X DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. }
(b) Diabetes mellitus
DUE TO
(c) Generalized arteriosclerosis, arteriosclerotic | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 days

? | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Intertrochanteric fracture, lt. hip (4/2/61) | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
9/3 | | (County)
1959 | | (State)
6/13 | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/3 to 6/13 , 19 61 , that (I) (we) last saw the deceased alive on 6/13 19 61 and that death occurred at 11:00 AM from the causes and on the date stated above. | | | | | | | | | | | | | | 22a. SIGNATURE
<i>Samuel M. Jacobson</i> M.D. | | 22b. DATE SIGNED
6/14/61 | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
SAMUEL M. JACOBSON | | | | 22d. ADDRESS
50 PERSHING ST., CUMBERLAND, MD. | | | | 22e. REC'D BY REGISTRAR
59 Greene St. | | | | 22f. REGISTRAR'S SIGNATURE
<i>Charles S. Kraus</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
6-16-61 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Grantsville Cemetery | | | | 23d. LOCATION (City, town or county)
Grantsville, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Paula H. Klotz</i> Hafer Funeral Home
E. Main, Frostburg, Md. | | | | | | | | | | | | | | 25a. JUN 19 '61 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles S. Kraus</i> | | | | | |

MEDICAL CERTIFICATION

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11:00 AM

SAMUEL M. JACOBSON

50 PERSHING ST., CLEVELAND, OH.

6-15-61

ALLERGY